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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036013	A. BUILDING: _____ B. WING _____	R 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NEW HOPE	1680 SOUTH NEW HOPE ROAD GASTONIA, NC 28054

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 02/04/25 to 02/05/25.	D 000	The following is the Plan of Correction for Brookdale New Hope Assisted Living regarding the Statement of Deficiencies dated 2/5/2025. The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding nor have we identified mitigating factors. We remain committed to the delivery of quality healthcare services and will continue to make changes and improvements to satisfy that objective.	
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 residents sampled (#3) was tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #3's current FL2 dated 10/29/24 revealed diagnoses included Type 2 diabetes, hypertension and congestive heart failure. Review of Resident #3's Resident Register	D 234	10A NCAC 13F .0703 (a) Tuberculosis test 1) Unable to retroactively correct the missing TB documentation for Resident #3 upon admission on 11/16/24. A new FL2 will be obtained along with appropriate TB testing upon admission. 2) An audit will be completed by the Health and Wellness Director/Designee no later than 3/11/25 for current residents. 3) Training, using the tracking system, will be conducted by the District Director of Clinical Services for the Executive Director, Health and Wellness Director and Sales Director by 3/11/25. Audits will be conducted by the ED/HWD/Designee weekly for 4 weeks and monthly for an additional 3 months. 4) To ensure ongoing compliance the ED/HWD/Designee will randomly audit FL2's and resident medical record for TB requirements. The results of the audits will be taken to QA meeting for analysis and ongoing improvement.	no later than 3/11/25

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Christy White TITLE Executive Director (X6) DATE 3/7/25

STATE FORM 6899 HWJ511 If continuation sheet 1 of 30

Reviewed and Acknowledged by SSD on 03/13/25 Sharon Dunton RN

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D 234	Continued From page 1 revealed an admission date of 11/16/24. Review of Resident #3's record revealed there was no documentation a TB skin test was completed prior to admission. Attempted interview with Resident #3 on 02/05/25 at 9:15am was unsuccessful. Interview with the Health and Wellness Director (HWD) on 02/05/25 at 3:23pm revealed: -There were no TB test results for Resident #3 in her record. -She was responsible for ensuring residents had a two-step TB test prior to admission into the facility. -The TB tests for Resident #3 were overlooked and not completed. Interview with the Administrator on 02/05/25 at 5:58pm revealed: -The HWD was responsible for ensuring all new residents had a TB test prior to admission. -She was not aware Resident #3 did not have a TB test done prior to admission to the facility.	D 234	.	.
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that	D 263	10A NCAC 13F .0802 (e) Resident Care Plan 1) The Health and Wellness Director, or Designee, will conduct chart audits for compliance 2) The Health and Wellness Director will utilize the tracking system to ensure ongoing compliance. 3) A new system will be devised for providers and the HWD to ensure proper communication and timely signature page completions.	no later than 3/11/2025

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D 263	Continued From page 2 justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure the care plan was signed by the Primary Care Provider (PCP) within 15 days from its completion for 2 of 5 sampled residents (#3 and #4). The findings are: 1. Review of Resident #3's current FL2 dated 10/29/24 revealed: -Diagnoses included hypertension, congestive heart failure (a condition when the heart does not pump blood as efficiently as it should), and atrial fibrillation (irregular heart rhythm). -Resident #3 was documented as being ambulatory, incontinent of bladder and continent of bowel. Review of Resident #3's Resident Register revealed she was admitted to the facility on 11/16/24. Review of Resident #3's care plan dated 12/18/24 revealed: -Resident #3 was independent with dressing, grooming and toileting. -Resident #3 used a walker for mobility. -The care plan was completed and electronically signed by the Health and Wellness Director (HWD). -The care plan was not signed by Resident #3's Primary Care Provider (PCP). Refer to the interview with the HWD on 02/05/25 at 04:19 pm.	D 263		

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D 263	Continued From page 3 Refer to the interview with the Administrator on 02/05/25 at 4:39pm. 2. Review of Resident #4's FL2 dated 01/28/25 revealed -Diagnoses included Alzheimer's disease, congestive heart failure, atrial fibrillation and hypertension. -Resident #4 was documented as being semi-ambulatory and incontinent of bowel and bladder. Review of Resident #4's Resident Register revealed she was admitted to the facility on 04/27/23. Review of Resident #4's most recent care plan dated 05/23/24 revealed: -Resident #4 did not require assistance with dressing and grooming. -Resident #4 used a walker for mobility assistance. -The care plan was completed and electronically signed by the HWD. -The care plan was not signed by the PCP. Refer to the interview with the HWD on 02/05/25 at 04:19 pm. Refer to the interview with the Administrator on 02/05/25 at 4:39pm. _____ Interview with the HWD on 02/05/25 at 4:19 pm revealed: -She was a Registered Nurse (RN). -She started working at the facility on 09/30/24. -She or the Area Manager were responsible for completing the assessment and care plan.	D 263		

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D 263	Continued From page 4 -They faxed the care plan to the PCP for a signature. -If the care plan had not been signed and the PCP was at the facility, we would have the PCP sign the care plan. -She was not aware the PCP needed to sign the care plan within 15 days from the completion date. -The missing PCP signature should have been followed up on and confirmed. Interview with the Administrator on 02/05/25 at 4:39pm revealed: -The HWD was responsible to complete resident care plans. -The PCP and the HWD should review the care plan for accuracy. -The HWD was responsible for sending the care plan to the PCP for a signature. -The HWD was responsible for tracking the care plan to ensure the PCP signed the care plan within 15 days.	D 263		
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 interviews and record reviews, the facility failed to ensure a physician order was implemented for 1 of 5 sampled residents who	D 276	10A NCAC 13F .0902 (c) (3-4) Health Care 1) Unable to retroactively correct resident #3's Warfarin administration. A clarification order will be obtained and entered in Point Click Care with the appropriate current Warfarin dosing. 2) An audit of current residents orders will be completed by the HEalth and Wellness Director/Designee to make sure orders for the last month are accurate and transcribed correctly in Point Click Care on the eMAR. 3) Training will be conducted by the Health and Wellness Director/Designee on the "New Order Tracking Form" for licensed and certified clinical associates no later than 3/11/2025. New Order Tracking will be reviewed daily by the HWD/Designee and compared to the eMAR for accuracy. 4) Results of audits will be taken to the monthly QA meeting for review and analysis.	no later than 3/11/2025

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D 276	Continued From page 5 had an order for a medication to thin blood (Resident #3). The findings are: Review of Resident #3's current FL2 dated 10/29/24 revealed diagnoses included hypertension, congestive heart failure (a condition when the heart does not pump blood as efficiently as it should), and atrial fibrillation (irregular heart rhythm). Review of Resident #3's Internal Medicine (IM) provider's order dated 01/14/25 revealed Resident #3's warfarin (a medication to thin blood) order was to be changed to warfarin 0.5mg on Mondays, Wednesdays, and Fridays and 1mg all other days of the week. Review of Resident #3's January 2025 electronic Medication Administration Record (eMAR) revealed there was no entry for warfarin 0.5mg on Mondays, Wednesdays, and Fridays and 1mg all other days of the week. Telephone interview with a representative with the facility's contracted pharmacy on 02/05/25 at 4:02pm revealed: -If orders were sent to the pharmacy electronically, they were automatically placed on the resident's eMAR. -If the pharmacy received a paper copy of an order, pharmacy staff would key the order into the system and facility staff would need to accept the order before it was on the resident's eMAR. -Facility staff did have the ability to enter orders into the residents' eMAR. -The pharmacy did not receive Resident #3's warfarin order dated 01/14/25.	D 276		

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D 276	Continued From page 6 Interview with a medication aide (MA) on 02/05/25 at 4:57pm revealed: -MAs, the Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD) were all able to process new orders, depending on who received the order. -All new orders were to be faxed to the pharmacy by the person processing the order. -The MAs, RCC and the HWD had the ability to enter new orders into the eMAR system. -When he received a new order for a resident, he first reviewed the new order with the resident's current orders in the eMAR system. -He then entered the new order into the eMAR system. -After entering orders into the eMAR system, the MAs were responsible for placing a copy of the order in the HWD's box so she could review the entered order for accuracy. Interview with the HWD on 02/05/25 at 3:23pm revealed: -The MAs, RCC, and she were responsible for faxing new orders to the pharmacy and keeping the fax confirmation page with the order. -She was responsible for reviewing all new orders entered into the eMAR system for accuracy. -Resident #3's warfarin order dated 01/14/25 was not entered into the eMAR system and therefore not implemented. -She was unsure if Resident #3's warfarin order dated 01/14/25 was faxed to the pharmacy because she was unable to locate the fax confirmation page. Interview with the Administrator on 02/05/25 at 5:58pm revealed: -The MAs, RCC and HWD were responsible for faxing all new orders to the pharmacy and entering the orders into the eMAR system.	D 276		

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D 276	Continued From page 7 -The HWD was responsible for reviewing all orders entered into the eMAR system for accuracy.	D 276	.	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 7 sampled residents with a diet order for a regular pureed diet (#4). The findings are: Review of Resident #4's current FL2 dated 01/28/25 revealed: -Diagnoses included Alzheimer's disease, congestive heart failure, atrial fibrillation and hypertension. -Resident #4 was documented as being semi-ambulatory and incontinent of bowel and bladder and did not need assistance with eating. -A diet order for regular pureed with nectar thick liquids. Review of Resident #4's resident register revealed she was admitted to the facility on 04/27/23. Review of Resident #4's record revealed:	D 310	10A NCAC 13F .0904 (e)(4) Nutrition and Food Services 1) Unable to retroactively correct the diet consistency for resident #4 for past meal delivery. A clarification order will be obtained by the Health and Wellness Director for the appropriate diet and communicated with the Dietary Director. 2) An audit of current resident's diets will be conducted by the Health and Wellness Director/Designee for accuracy in transcription and communication to the Dietary Director and licensed, certified and non-certified associates by 3/11/25. Diets will be audited weekly for four weeks by the Health and Wellness Director with ongoing random audits. 3) Training for the Executive Director and Health and Wellness Director by the District Director of Clinical Services on diet orders and accuracy of communication and on the Personal Service Plan for the Dietary Department and licensed and certified associates no later than 3/11/25. 4) Results of audits will be reviewed in the QA meeting for ongoing analysis and improvement.	no later than 3/11/2025

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D 310	Continued From page 8 -She was admitted to the hospital on 12/24/24 for increased confusion. -She returned to the facility on 01/29/25 from a skilled nursing facility. Review of the therapeutic diet list posted in the kitchen dated 02/03/25 revealed Resident #4 was to receive a textured modified diet. Review of the lunch meal menu service for 02/05/25 revealed a choice of beef goulash, caramelized carrots and pasta of the day, Brunswick stew or egg salad sandwich. Observation of the lunch meal service on 02/05/24 at 12:45 revealed: -Resident #4 ate in her room. -Resident #4 received Chopped Swiss steak, roll, chopped carrots and nectar thick iced tea and thickened water. -Resident #4's tray was removed before reviewing her consumption. Review of the therapeutic diet modification menu for a pureed menu revealed Resident #4 should have received swiss steak puree with gravy, pureed carrots and pureed bread/roll. Interview with the Residential Care Coordinator (RCC) on 02/04/25 at 4:56pm revealed: -She was not aware Resident #4's diet had changed to a regular pureed diet. When a Resident returned from a hospitalization or rehabilitation stay, the paperwork should be given to the medication aide (MA) who should give it to the Health and Wellness Director (HWD). -She or the HWD was responsible for giving a copy of the diet order to the Dietary Manager (DM).	D 310		

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D 310	Continued From page 9 Interview with a cook on 02/04/25 at 5:11pm revealed he was not aware Resident #4's diet order had changed to a regular pureed diet. Interview with a personal care aide (PCA) on 02/04/25 at 5:11pm revealed she was not aware Resident #4 was on a regular pureed diet with nectar thickened liquids and thought Resident #4 was on a textured modified diet with nectar thickened liquids. Interview with a medication aide (MA) on 02/05/25 at 5:13pm revealed: -When a resident would come back from the hospital or rehabilitation facility the transporter would hand any discharge paperwork for the resident to the MA who was responsible to review any new orders or after visit/discharge summary. -He would look at the FL2 and transcribe the new order onto a new order sheet which would go to the Primary Care Provider (PCP). -A note should be documented in the resident's medical record pertaining to any changes. -The original copy goes to the HWD, and a copy should be placed in the resident's medical record. Interview with the Administrator on 02/04/25 at 5:20pm revealed: -She was not aware of Resident #4's diet change. -The HWD was to review the FL2 to see if there were any changes and ensure the change is communicated to all departments relating to Resident #4's care and updated in the resident's record. Interview with the Dietary Manager (DM) on 02/05/24 at 2:38pm revealed: -She was not aware of Resident #4's diet order to regular pureed food.	D 310		

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D 310	Continued From page 10	D 310		

She was aware Resident #4 was on nectar thickened liquid and textured modified diet prior to her hospitalization.
-All new diet orders are given to her by the HWD or RCC.
-When she received a signed physician diet order it was placed in her resident diet binder.
-She was responsible for completing the resident diet list with any new diet changes.

Interview with the HWD on 02/05/25 at 9:59am and 4:19 pm revealed:
-She was a Registered Nurse (RN)
-She started working at the facility on 09/30/24.
-When a Resident returned from a hospitalization or rehabilitation stay, the after visit/discharge summary paperwork should be given to a MA supervisor who was to make a copy and give to the RCC or HWD to review for any changes.
-Resident #4's FL2 was put directly in her record and a copy was not given to the RCC or HWD to review for any changes.
-The FL2 should have been reviewed for any changes including changes in diet and confirmed and followed up with her and if necessary, call the Rehabilitation facility to clarify the new diet order.

Interview with the Administrator on 02/05/25 at 4:39pm revealed:
-The HWD or the RCC should communicate new diet orders to the Dietary Manager.
-When Resident #4 returned to the facility the HWD had communicated to the MA Supervisor to process any new orders, however the paperwork was filed, and no one knew Resident #4's diet order had changed.
-A copy should have been made and given to the HWD for review.
-It was her expectation that the process that had been put in place was followed and the FL2

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D 310	Continued From page 11 should be reviewed in all areas.	D 310	.	
D 354	10A NCAC 13F .1003 (c) Medication Labels 10A NCAC 13F .1003 Medication Labels (c) The facility shall assure the container is relabeled by a licensed pharmacist or a dispensing practitioner at the refilling of the medication when there is a change in the directions by the prescriber. The facility shall have a procedure for identifying direction changes until the container is correctly labeled. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication containers had correct labels for 2 of 6 sampled residents related to a medication to thin blood (#3 and #8) and a supplement to treat anemia (low red blood cell count) (#3). The findings are: 1. Review of Resident #3's current FL2 dated 10/29/24 revealed diagnoses included hypertension, congestive heart failure (a condition when the heart does not pump blood as efficiently as it should), and atrial fibrillation (irregular heart	D 354	10A NCAC 13F .1003 (c) Medication Labels 1) Unable to retroactively correct the medication labels for residents #3 and #8. Clarification orders to be obtained by the Health and Wellness Director. 2) A MAR to Cart audit will be conducted for current residents by the pharmacy and the Health and Wellness Director/Designee no later than 3/11/25. 3) Training for the HWD and licensed and certified clinical associates will be conducted by the District Director of Clinical Services on medication labels and the process of receiving medication from the pharmacy on direction change labels no later than 3/11/25. The HWD/ Designee will conduct cart and chart audits weekly for the next four weeks with ongoing random audits monthly. 4) Results of audits will be reviewed in the next QA meeting for accuracy of medication change labels for analysis and ongoing improvement.	no later than 3/11/2025

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	HAL036013	A. BUILDING: _____ B. WING _____	R 02/05/2025

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D 354	Continued From page 12	D 354		

rhythm).

a. Review of Resident #3 signed Primary Care Provider's (PCP) orders dated 01/15/25 revealed there was an order for warfarin 1mg, 1.5 tablets daily on Mondays, Tuesdays, Wednesdays, Thursdays, Fridays and Sundays.

Review of Resident #3's PCP order dated 01/17/25 revealed Resident #3 was to continue to receive warfarin 1mg, 1.5 tablets daily every day except Saturdays.

Review of Resident #3's Specialty Clinic order dated 01/21/25 revealed Resident #3 was to receive warfarin 1mg daily.

Observation of Resident #3's medications on hand on 02/05/25 at 10:16am revealed:
-There were three bubble packs of warfarin 1mg on the medication cart for Resident #3.
-The was a bubble pack dispensed on 01/16/25 for Resident #3 containing warfarin 1mg, 0.5 tablets with directions to administer 1.5 tablets every Sunday, Monday, Tuesday, Wednesday, Thursday and Friday.
-There were 22 of 26 warfarin 1mg, 0.5 tablets remaining in the bubble pack.
-There was a second bubble pack dispensed on 01/16/25 for Resident #3 containing warfarin 1mg tablets, with directions to administer 1.5 tablets every Sunday, Monday, Tuesday, Wednesday, Thursday and Friday.
-The second bubble pack containing warfarin 1mg tablets had 9 tablets remaining of 26 tablets dispensed.
-There was a third bubble pack dispensed on 01/31/25 for Resident #3 containing warfarin 1mg, seven tablets with directions to administer one tablet daily and recheck (INR blood test, a

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D 354	Continued From page 13	D 354		

blood-clotting test) in one week.
-The third bubble pack contained all seven warfarin 1mg tablets dispensed on 01/31/25.
-There were no change of direction stickers on the three warfarin bubble packs for Resident #3.

Refer to the telephone interview with a representative from the facility's contracted pharmacy on 02/05/25 at 4:02pm.

Refer to the interview with a medication aide (MA) on 02/05/25 at 4:57pm.

Refer to the interview with the Health and Wellness Director (HWD) on 02/05/25 at 5:30pm.

Refer to the interview with the Administrator on 02/05/25 at 5:58pm.

b. Review of Resident #3 hospital discharge summary dated 12/24/24 revealed an order to change Resident #3 ferrous sulfate (a supplement to increase red blood cell counts) to 325mg, one tablet daily.

Observation of Resident #3's medications on hand on 02/05/25 at 10:16am revealed:
-There were three bubble packs of ferrous sulfate 325mg on the medication cart for Resident #3.
-There were two bubble packs dispensed on 12/18/24 for Resident #3 containing ferrous sulfate 325mg with directions to administer one tablet three times daily.
-There were 3 tablets of ferrous sulfate 325mg out of 30 tablets dispensed remaining in the first bubble pack.
-There were 29 tablets of ferrous sulfate 325mg out of 30 tablets dispensed remaining in the second bubble pack.
-There was a third bubble pack dispensed on

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D 354	Continued From page 14 01/12/25 for Resident #3 containing ferrous sulfate 325mg with directions to administer one tablet three times daily. -The third bubble pack was full and contained 30 tablets of ferrous sulfate 325mg. -There were no change of direction stickers on the three ferrous sulfate 325mg bubble packs for Resident #3. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 02/05/25 at 4:02pm. Refer to the interview with a medication aide (MA) on 02/05/25 at 4:57pm. Refer to the interview with the Health and Wellness Director (HWD) on 02/05/25 at 5:30pm. Refer to the interview with the Administrator on 02/05/25 at 5:58pm. 2. Review of Resident #8's current FL2 dated 07/03/24 revealed diagnoses included hypertension, heart failure (a condition when the heart does not pump blood as efficiently as it should), and atrial fibrillation (irregular heart rhythm). a. Review of Resident #8 signed Primary Care Provider's (PCP) orders dated 12/04/24 revealed: -There was an order for warfarin 2mg, one tablet on Tuesdays, Thursdays, and Saturdays. -There was an order for warfarin 3mg, one tablet on Mondays, Wednesdays, Fridays and Sundays. Observation of Resident #8's medications on hand on 02/05/25 at 4:15pm revealed: -There were two bubble packs of warfarin 2mg tablets dispensed 01/19/25 with directions to	D 354		

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D 354	Continued From page 15	D 354		

administer one and one-half tablet every Monday and Friday and take one tablet every Tuesday, Wednesday, Thursday, Saturday and Sunday.
-There were no change of direction stickers on the two warfarin bubble packs for Resident #8.

Refer to the telephone interview with a representative from the facility's contracted pharmacy on 02/05/25 at 4:02pm.

Refer to the interview with a medication aide (MA) on 02/05/25 at 4:57pm.

Refer to the interview with the Health and Wellness Director (HWD) on 02/05/25 at 5:30pm.

Refer to the interview with the Administrator on 02/05/25 at 5:58pm.

Telephone interview with a representative from the facility's contracted pharmacy on 02/05/25 at 4:02pm revealed:
-If the facility sent a resident's order to the pharmacy and accepted the order entered by the pharmacy, the medication label should match the medications dispensed from the pharmacy.
-It was the facility's responsibility to check the label with the order and notify the pharmacy if it did not match.
-The pharmacy had 'directions changed' stickers available for the facility to place on medications when it was appropriate to continue the dosage of medication available on the medication cart.

Interview with a medication aide (MA) on 02/05/25 at 4:57pm revealed:
-He followed the directions on the resident's eMAR when administering medications.
-There were 'direction change' stickers on the medication cart to put on medications in which

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D 354	Continued From page 16 the label did contain the correct order -It was the responsibility of the MA receiving the order change to place the 'direction change' sticker on the medication. Interview with the HWD on 02/05/25 at 5:30pm revealed: -MAs were responsible to administer medications according to the orders in the eMAR system. -If a medication label did not match the order in the eMAR system, the medication should be pulled and the order reviewed. -She was not aware there were 'direction change' stickers that could be placed on medications in which the order had been changed. Interview with the Administrator on 02/05/25 at 5:58pm revealed: -The MAs were responsible to contact the pharmacy if a medication label did not match the medication order in the eMAR system. -She was not aware there were 'direction change' stickers that could be placed on medications in which the order had been changed.	D 354		
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.	D 358	10A NCAC 13F .1004 (a) Medication Administration 1) Unable to retroactively correct resident #3's Warfarin administration. Clarification order obtained and entered into eMAR, Warfarin confirmed as available for administration per Physicians orders by the Health and Wellness Director/ Designee. 2) An audit of current residents orders will be completed by the Health and Wellness Director/Designee to make sure orders for the last month are accurate, transcribed and available for administration.	no later than 3/11/2025

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D 358	Continued From page 17 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 5 sampled residents (#3) related to a medication to thin blood, a medication to treat congestive heart failure (a condition when the heart does not pump blood as efficiently as it should) and a medication to lower cholesterol levels. The findings are: Review of Resident #3's current FL2 dated 10/29/24 revealed diagnoses included hypertension, congestive heart failure and atrial fibrillation (irregular heart rhythm). a. Review of Resident #3 Primary Care Provider's (PCP) order dated 01/03/25 revealed: -Warfarin (a medication to thin blood) 1mg, one and one-half tablets were to be administered to Resident #3 on Mondays, Tuesday, Wednesdays, Thursdays, Fridays and Sundays. -No warfarin was to be administered to Resident #3 on Saturdays. Review of Resident #3's Internal Medicine (IM) provider's order dated 01/14/25 revealed Resident #3's warfarin order was to be changed to warfarin 0.5mg on Mondays, Wednesdays, and Fridays and 1mg all other days of the week. Review of Resident #3's January 2025 electronic Medication Administration Record revealed: -There was an entry dated 01/05/25 for warfarin 1mg, administer one and one-half tablets on Mondays, Tuesdays, Wednesdays, Thursdays, Fridays and Sundays. -The entry was discontinued on 01/22/25. -Warfarin 1mg, one and one-half tablets was	D 358	continued from previous page 3)Training will be conducted by the Health and Wellness Director/Designee on the "New Order Tracking Form" for licensed and certified clinical associates no later than 3/11/25. New Order Tracking will be reviewed daily by the HWD/Designee and compared to the eMAR for accuracy. Training on the process for obtaining medication from the pharmacy or other source. 4)To assist with ongoing compliance, the Health and Wellness Director/Designee will review the Medication Administration Report weekly. Results of audits will be taken to the monthly QA meeting for review and analysis.	

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D 358	Continued From page 18 documented administered at 5:00pm from 01/05/25 to 01/08/25 and from 01/19/25 to 01/21/25. -Warfarin 1mg, one and one-half tablets was documented not administered from 01/09/25 to 01/10/25 as it was placed on hold. -Warfarin 1mg, one and one-half tablets was documented not administered on Saturdays, 01/11/25 and 01/18/25. -Warfarin 1mg, one and one-half tablets was documented not administered from 01/12/25 to 01/17/25 due to medication not available. Review of Resident #3's progress notes revealed: -There was documentation on 01/09/25 at 9:35am Resident #3's warfarin was placed on hold for two days and then was to resume. -There was documentation on 01/12/25 at 4:25pm, on 01/13/25 at 3:15pm, on 01/14/25 at 3:13pm, on 01/15/25 at 3:13pm, and on 01/16/25 at 3:41pm Resident #3 did not receive warfarin as the medication was not available to administer. -There was documentation on 01/13/25 at 11:44am Resident #3's PCP's office was contacted concerning Resident #3's warfarin. -There was documentation on 01/15/25 at 11:45am Resident #3's PCP signed orders and was updated on prior communication concerning low warfarin. Observation of Resident #3's medications on hand on 02/05/25 at 10:16am revealed: -There were three bubble packs of warfarin 1mg on the medication cart for Resident #3. -There was a bubble pack dispensed on 01/16/25 for Resident #3 containing warfarin 1mg, 0.5 tablets with directions to administer 1.5 tablets every Sunday, Monday, Tuesday, Wednesday, Thursday and Friday. -There were 22 of 26 warfarin 1mg, 0.5 tablets	D 358		

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D 358	Continued From page 19 remaining in the bubble pack. -There was a second bubble pack dispensed on 01/16/25 for Resident #3 containing warfarin 1mg tablets, with directions to administer 1.5 tablets every Sunday, Monday, Tuesday, Wednesday, Thursday and Friday. -The second bubble pack containing warfarin 1mg tablets had 9 tablets remaining of 26 tablets dispensed. -There was a third bubble pack dispensed on 01/31/25 for Resident #3 containing warfarin 1mg, seven tablets with directions to administer one tablet daily and recheck (INR blood test, a blood-clotting test) in one week. -The third bubble pack contained all seven warfarin 1mg tablets dispensed on 01/31/25. Telephone interview with a representative from the facility's contracted pharmacy on 02/05/25 at 4:02pm revealed: -On 12/11/24, warfarin 1mg, 9 tablets, (seven-day supply) were dispensed for Resident #3 with directions to take one tablet on Monday, Tuesday, Thursday, Friday and one and one-half tablets on Wednesday, Saturday and Sunday. -On 12/18/24, warfarin 1mg, 10 tablets, (seven-day supply) were dispensed for Resident #3 with directions to take one and one-half tablet on Monday, Tuesday, Wednesday, Thursday, Friday and one tablet on Saturday and Sunday. -On 01/17/25, warfarin 1mg, 28 tablets, were dispensed for Resident #3 with directions to take one and one-half tablet on Monday, Tuesday, Wednesday, Thursday, Friday and Sunday with no warfarin on Saturday. -If Resident #3 did not receive warfarin as ordered from 01/12/25 to 01/19/25 she could have increased risk for blood clots. Telephone interview with Resident #3's PCP on	D 358		

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D 358	Continued From page 20 02/05/25 at 3:23pm revealed: -She was Resident #3's PCP since 12/18/24 but did not begin managing her warfarin until 02/04/25 -On 01/17/25, the on-call provider with her company sent a 30-day order for Resident #3 for warfarin 1mg, one and one-half tablets daily except on Saturdays. -If Resident #3 did not receive her warfarin as prescribed she could experience blood clots and pulmonary embolisms (blood clots in the lung). Interview with a medication aide (MA) on 02/05/25 at 4:57pm revealed: -He did remember Resident #3 running out of warfarin but was unsure when it occurred. -The pharmacy had sent two cards of warfarin 1mg; one card contained whole 1mg tablets and the other card contained warfarin 1mg, one-half tablets. -He thought Resident #3 may have run out of warfarin because when the MAs were out of Resident #3 warfarin half tablets, they had to cut the whole tablets in half and wasted the other half. -He was unsure of the date, but the Resident Care Coordinator (RCC) and Health and Wellness Director (HWD) were made aware of Resident #3 being out of her warfarin. Refer to the interview with a MA on 02/05/25 at 4:57pm. Refer to the interview with the HWD on 02/05/25 at 5:30pm. Refer to the interview with the Administrator on 02/05/25 at 5:58pm. b. Review of Resident #3 hospital discharge	D 358		

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summary dated 12/24/24 revealed there was an order for sacubitril-valsartan (a medication to treat congestive heart failure) 29-51mg, one tablet twice daily.

Review of Resident #3's January 2025 eMAR revealed:
-There was an entry for sacubitril-valsartan 49-51mg, one tablet twice daily at 9:00am and 8:00pm.
-Sacubitril-valsartan 49-51mg, one tablet was documented not administered 01/12/25 at 8:00pm, on 01/13/25 at 8:00pm, on 01/14/25 at 9:00am and 8:00pm, on 01/15/25 at 8:00pm and on 01/16/25 at 9:00am and 8:00pm due to the medication not available.

Review of Resident #3's progress notes revealed:
-There was documentation on 01/12/25 at 8:03pm Resident #3 did not receive sacubitril-valsartan 49-51mg, one tablet as the medication was not available to administer.
-There was documentation on 01/13/25 at 11:44am Resident #3's PCP's office was contacted concerning Resident #3's sacubitril-valsartan 49-51mg.
-There was documentation on 01/13/25 at 7:34pm Resident #3 did not receive sacubitril-valsartan 49-51mg, one tablet as the medication was not available to administer.
-There was documentation on 01/15/25 at 11:45am Resident #3's PCP signed orders and was updated on prior communication concerning low sacubitril-valsartan 49-51mg.

Telephone interview with a representative from the facility's contracted pharmacy on 02/05/25 at 4:02pm revealed:
-On 12/03/24, sacubitril-valsartan 49-51mg, 28 tablets were dispensed for Resident #3 with

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D 358	Continued From page 22 directions to take one tablet twice daily. -On 12/04/24, sacubitril-valsartan 49-51mg, 32 tablets were dispensed for Resident #3 with directions to take one tablet twice daily. -On 01/16/25 the pharmacy received a new order for sacubitril-valsartan 49-51mg, one tablet twice daily and 60 tablets were dispensed for Resident #3 that day (01/16/25). -If Resident #3 did not receive sacubitril-valsartan 49-51mg as ordered she was at increased risk of high blood pressure and edema (swelling). Telephone interview with Resident #3's PCP on 02/05/25 at 3:23pm revealed: -After reviewing her records, she did not see any requests from the facility to refill Resident #3's sacubitril-valsartan 49-51mg. -On 01/16/24 her office sent an order for Resident #3's sacubitril-valsartan 49-51mg, 60 tablets with directions to take one tablet twice daily. -Sacubitril-valsartan 49-51mg was a combination medication and was used to treat heart failure, decrease edema, and lower blood pressure. -She was not aware Resident #3 had missed seven doses of sacubitril-valsartan 49-51mg and it may have contributed to Resident #3's continued edema. -She expected the facility to notify her when they were running low on medications so she could refill them before the residents ran out of their medications. Refer to the interview with a MA on 02/05/25 at 4:57pm. Refer to the interview with the HWD on 02/05/25 at 5:30pm. Refer to the interview with the Administrator on	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036013	A. BUILDING: _____ B. WING _____	R 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NEW HOPE	1680 SOUTH NEW HOPE ROAD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 23 02/05/25 at 5:58pm. c. Review of Resident #3 hospital discharge summary dated 12/24/24 revealed there was an order for rosuvastatin (a medication to lower cholesterol levels) 5mg, one tablet at bedtime. Review of Resident #3's January 2025 eMAR revealed: -There was an entry for rosuvastatin 5mg, one tablet at bedtime at 8:00pm. -Rosuvastatin 5mg, one tablet at bedtime was documented not administered at 8:00pm from 01/09/25 to 01/17/25 due to the medication not available. Review of Resident #3's progress notes revealed: -There was documentation on 01/09/25 at 7:54pm, on 01/10/25 at 7:14pm, on 01/12/25 at 8:04pm, and on 01/13/25 at 7:36pm Resident #3 did not receive rosuvastatin 5mg, one tablet as the medication was not available to administer. -There was documentation on 01/13/25 at 11:44am Resident #3's PCP's office was contacted concerning Resident #3's rosuvastatin 5mg. -There was documentation on 01/15/25 at 11:45am Resident #3's PCP signed orders and was updated on prior communication concerning low rosuvastatin. -There was documentation on 01/17/25 at 7:09pm Resident #3 did not receive rosuvastatin 5mg, one tablet as the medication had not yet been received. Telephone interview with a representative from the facility's contracted pharmacy on 02/05/25 at 4:02pm revealed: -On 12/03/24, rosuvastatin 5mg, 30 tablets were dispensed for Resident #3 with directions to take	D 358		

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one tablet daily.
-On 01/17/25 the pharmacy received a new order for rosuvastatin 5mg, one tablet daily and 30 tablets were dispensed for Resident #3 that day (01/17/25).
-If Resident #3 did not receive rosuvastatin 5mg as prescribed, her cholesterol levels could increase.

Telephone interview with Resident #3's PCP on 02/05/25 at 3:23pm revealed:
-On 01/17/25, the on-call provider with her company sent a 30-day order for Resident #3 for rosuvastatin 5mg, one tablet daily at bedtime.
-Rosuvastatin 5mg was a medication to control plaque build-up in the vessels of the heart.
-She was not aware Resident #3 missed nine doses of rosuvastatin 5mg.
-She expected the facility to notify her when they were running low on medications so she could refill them before the residents ran out of their medications.

Refer to the interview with a MA on 02/05/25 at 4:57pm.

Refer to the interview with the HWD on 02/05/25 at 5:30pm.

Refer to the interview with the Administrator on 02/05/25 at 5:58pm.

Interview with a MA on 02/05/25 at 4:57pm revealed:
-The MAs were responsible for reordering residents' medications when there were 14 doses of a medication remaining.
-If a medication was unavailable to administer, the MAs were responsible for contacting the pharmacy to find out why the medication was not

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available.
-If the pharmacy required a new PCP order, the MAs were responsible for contacting the PCP.
-If an MA had difficulty getting medication they were to inform the RCC and the HWD.

Interview with the HWD on 02/05/25 at 5:30pm revealed:
-The MAs were responsible for ordering medications from the pharmacy when there were seven days of medication left.
-If a medication was not available, the MAs were responsible to reach out to the pharmacy and document the communication on the clinical communication board in the electronic system.
-The third shift MAs were responsible for nightly medication cart audits and to document the findings in the three-ring binder and the clinical communication board.
-She was responsible for performing a missed medication report daily.
-She did not recall three medications being unavailable for Resident #3 in January 2025.

Interview with the Administrator on 02/05/25 at 5:58pm revealed:
-The MAs were responsible for ordering medications from the pharmacy when there were seven days of medication left.
-The MAs were responsible for contacting the pharmacy when medication was not available for administration.
-The MAs were responsible for contacting the PCP if the pharmacy required a new order.
-The MAs were responsible to make the HWD aware when resident medications were not available for administration.
-The third shift MAs were responsible for nightly medication cart audits.
-She expected the HWD to review the medication

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D 358	Continued From page 26 cart audits weekly.	D 358	.	
D 387	10A NCAC 13F .1007 (b) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (b) Medications, excluding controlled medications that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored separately from actively used medications until disposed of. This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to ensure discontinued medications were stored separately from actively used medications for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's Resident Register revealed she was admitted to the facility on 11/16/24. Review of Resident #3's current FL2 dated 10/29/24 revealed: -Diagnoses included hypertension, congestive heart failure (a condition when the heart does not pump blood as efficiently as it should), and atrial fibrillation (irregular heart rhythm). -There was an order for furosemide 20mg, three tablets daily. Review of Resident #3's Primary Care Provider's (PCP) visit note dated 12/18/24 revealed: -Resident #3 had right lower extremity edema	D 387	10A NCAC 13F .1007 (b) Medication Disposition 1) Resident #3 medications that had been discontinued was removed from the cart by the Health and Wellness Director/ Designee, clarification order for current Lasix dosage has been obtained and the correct dosing is currently in the cart available for administration. 2) The HEalth and Wellness Director is partnering with the pharmacy on completing an eMAR to cart audit to confirm that orders are correct and only active medication orders remain on the cart for administration. All unused or discontinued medications will be returned to the pharmacy no later than 3/11/25. 3) Audits will be conducted by the HWD/Designee weekly for four weks to confirm ongoing compliance. 4) To assist in ongoing compliance, the results of audits will be addressed at the next QA meeting for review and analysis.	no lather than 3/11/2025

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(swelling).
-There was an order to increase Resident #3's furosemide to 80mg daily for 3 days and then resume previous order of furosemide 60mg daily.

Review of Resident #3's PCP order dated 01/03/25 revealed:
-Resident #3's current furosemide order was discontinued.
-Furosemide 40mg, one tablet daily was ordered for Resident #3.

Review of Resident #3's PCP order dated 01/08/25 revealed:
-Resident #3's furosemide 40mg, one tablet daily order was discontinued.
-Furosemide 40mg, two tablets daily was ordered for Resident #3.

Review of Resident #3's PCP order dated 01/22/25 revealed Resident #3's furosemide 40mg, two tablets daily order was discontinued.

Observation of medications on hand for Resident #3 on 02/05/25 at 10:16am revealed:
-There were four bubble packs of furosemide on the medication cart with Resident #3's active medications.
-The facility's contracted pharmacy dispensed 90 tablets of furosemide 20mg, three tablets daily, in three bubble packs of 30 tablets each on 12/03/24.
-The bubble pack containing furosemide 20mg, three tablets daily was labeled bubble pack two of three and had 15 tablets remaining in the bubble pack.
-The facility's contracted pharmacy dispensed three tablets of furosemide 80mg, one tablet daily for three days on 12/18/24 and one tablet remained in the bubble pack.

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D 387	Continued From page 28 -The facility's contracted pharmacy dispensed 30 tablets of furosemide 40mg, one tablet daily on 01/03/25 and all 30 tablets remained in the bubble pack. -The facility's contracted pharmacy dispensed 60 tablets of furosemide 40mg, two tablets daily on 01/11/25 and 42 tablets remained in the bubble pack. Interview with a medication aide (MA) on 02/05/25 at 10:36am revealed: -If a MA received a new order for a medication change, they should take the discontinued medication off of the medication cart. -Sometimes the MA left the discontinued medication on the medication cart in case the order changed back to the previous order. -Resident #3 had several changes in her furosemide order and she believed that could be the reason the medications were left on the medication cart. -There was no locked area outside of the medication cart to store discontinued medications. -The pharmacy did not always pick up discontinued medications timely and that was the reason they were stored on the medication cart. Interview with the Health and Wellness Director (HWD) on 02/05/25 at 5:30pm revealed: -MAs were responsible for removing discontinued medications from the medication carts. -There was a locked storage area in the medication room for discontinued medications to be stored prior to returning them to the pharmacy or disposing of them. -The third shift MAs were responsible for completing medication cart audits and should remove any non-active medications from the medication cart.	D 387		

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D 387	Continued From page 29 Interview with the Administrator on 02/05/25 at 5:58pm revealed: -She expected MAs to pull discontinued medications from the medication cart immediately after an order was discontinued. -There was an area in the medication room for storing discontinued medications before they were sent back to the pharmacy. -The third shift MAs were responsible to complete cart audits nightly and were responsible for removing any discontinued medications.	D 387		