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
	HAL029013	A. BUILDING: _____ B. WING _____	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE TERRACE OF THOMASVILLE	915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360

(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 from 06/10/26 through 06/11/26.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure referral and follow-up for 1 of 5 sampled residents (#3) related to a provider order that was not completed to check blood pressure (BP) for 7 days with notification parameters. The findings are: Review of Resident #3's current FL2 dated 03/30/26 revealed diagnoses included dementia, chronic pain, legally blind, and anxiety. Review of Resident #3's signed physician's order dated 05/11/26 revealed there was an order for BP to be measured in the morning and evening for the next 7 days and to notify triage/provider if systolic BP was less than 90 or greater than 180 or if diastolic BP was less than 60 or greater than 100. Review of Resident #3's record and May 2026 electronic medication administration record (eMAR) from 05/11/26 to 05/18/26 revealed: -There was documentation Resident #3's BP was 160/63 on 05/13/26 at 3:38pm. -There were no other documented BP values available for review.	D 273	In reviewing this deficiency, RCD learned that the physician Triage does not transmit any orders other than medications. The facility staff is required to fax any other orders directly to the pharmacy when the orders are coming from Triage rather than the physician. Supervisor's, Managers and Med Tech's have all been retrained to fax non medication orders so that the orders are added to the MAR. Upon learing of the missed order, the order was immediately faxed to the pharmacy for entry to the MAR. The RCD reviewed the resident's MAR for accuracy and the order was followed per physician orders.	Immediate & ongoing Immediate & ongoing

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Yvonne D. Pittman — TITLE: Administrator — (X6) DATE: 7-14-26

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D 273	Continued From page 1 Telephone interview with a representative from the facility's contracted pharmacy on 06/11/26 at 3:15pm revealed: -There was no record of Resident #3's provider order dated 05/11/26 to check BP twice daily for 7 days in the pharmacy's electronic system. -The pharmacy normally added provider orders to resident eMARs automatically if an order was sent to the pharmacy. -She did not know if the facility was able to add provider orders to the eMARs. Attempted telephone interview with Resident #3's primary care provider (PCP) on 06/11/26 at 3:00pm was unsuccessful. Interview with the Supervisor on 06/11/26 at 3:35pm revealed: -She did not know Resident #3 had a provider order dated 05/11/26 to check Resident #3's BP twice daily for 7 days. -She helped with order processing and the RCD printed provider orders to place in residents' records. -The Resident Care Director (RCD) normally ensured provider orders were on the residents' eMARs. Interview with the RCD on 06/11/26 at 4:20pm revealed: -She thought she had seen the order to check Resident #3's BP for 7 days before 06/11/26. -She did not know why the pharmacy did not receive the order for Resident #3's BP. -Resident BP values were documented on the eMARs. -If the provider wrote an order, the facility normally faxed the order to the pharmacy and the order entry was added to the eMAR.	D 273	To ensure that no orders from Triage and/or physicians are missed, the RCD will review all incoming orders daily . A "Faxed to Pharmacy" verification step has been added to the order processing workflow before orders are filed. All SIC's, Med Tech's & Managers have been trained on this verification The RCD or Designee will perform cart audits weekly to ensure that all orders are represented in the Mar and that all medications are on-site for administration.	Immediate & ongoing Immediate & ongoing Immediate & ongoing

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D 273	Continued From page 2 -Sometimes the provider wrote orders while the provider was at the facility but other times the provider wrote orders elsewhere and electronically transmitted the orders to the pharmacy. -If an order was electronically transmitted to the pharmacy, the order would be emailed to her and she printed off the order. -She would have been responsible to follow-up and ensure Resident #3's order to check BP twice daily for 7 days was on the eMAR. Interview with the Administrator on 06/11/26 at 4:06pm revealed: -She did not know Resident #3 had a provider order dated 05/11/26 to check Resident #3's BP twice daily for 7 days until 06/11/26. -The pharmacy normally placed order entries on the resident eMARs. -The Supervisor received provider orders and the RCD reviewed provider orders. -The medications aides followed the eMARs for provider orders. -Both the Supervisor and the RCD were responsible to ensure provider orders were on the eMARs. Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable.	D 273		