

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/11/2026
NAME OF PROVIDER OR SUPPLIER BROOKDALE CHAPEL HILL AL (NC)		STREET ADDRESS, CITY, STATE, ZIP CODE 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 and follow-up survey on 06/09/26 to 06/11/26.	D 000	The following is the Plan of Correction for Brookdale Chapel Hill Assisted Living regarding the Statement of Deficiencies dated 6/9/2026. This 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 health care services and will continue to make changes and improvement to satisfy that objective.	7/26/26
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 facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure 4 of 4 exit doors had a continuously sounding device that was operational and audible throughout the facility and were accessible to two residents who were intermittently disoriented (#7 and #8).	D 067	Executive Director and/or designee equipped all exits of the community with an Arial sounding device that is activated when the door is open outside of regular business hours. A sounding device (doorbell) was installed on each exit door. Executive Director or designee will retrain the community management and associates on exit door safety. Maintenance Manager or designee will perform routine checks on the alarms and the work order will be placed in the community TELS system. To assist with ongoing compliance, the ED or designee will audit the routine check results weekly for 1(one) month and monthly for the next six (6) months. In addition, when an exit door opens, the pagers will be sent a continuous signal from the Arial system. All exit doors will be locked between 7pm to 7am.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Iwona Hughes

Executive Director

7/24/26

STATE FORM

6899

BIMX11

If continuation sheet 1 of 25

Reviewed and acknowledged SW 07/24/26

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D 067	Continued From page 1 The findings are: Observation of the facility's front entrance door on 06/09/26-06/11/26 at various times between 8:00am-5:45pm revealed: -The door opened and closed without the sound of a continuous alarm. -There was a receptionist area at the front door, staff were intermittently present and on multiple occasions staff were not at the desk. Observation of the C-hall on 06/10/26 at 8:28am revealed: -There was a common area/sitting room with an exterior door. -The exterior door was partially open. -The exterior door led to a small sitting area. -There was a resident sitting in a chair outside in the sitting area. Observation of the A-hall on 06/10/26 at 11:12pm revealed: -There was an exit door in the physical therapy (PT) room. -The door exited to an enclosed courtyard. -The door opened and closed without the sound of a continuous alarm. Observation of the B-hall on 06/10/26 at 11:46pm revealed: -Each hall had a common area/sitting room for the residents. -There was an exit door in the common area/sitting room. -The door exited to an enclosed courtyard. -The door opened and closed without the sound of a continuous alarm. Observation of the C-hall on 06/10/26 at 12:16pm revealed:	D 067			

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D 067	Continued From page 2 -The door exited to the residents' enclosed smoking area. -The door opened and closed without the sound of a continuous alarm. 1. Review of Resident #8's current FL2 dated 11/21/25 revealed: -Diagnoses included hypertension and allergies. -Resident #8 was intermittently disoriented. Review of Resident #8's care plan dated 07/09/25 revealed: -Resident #8 had memory loss and dementia. -Resident #8 had a cognitive deficit. Observation of Resident #8 on 06/09/26 at 1:15pm revealed: -A resident opened the doors by pushing the automatic handicap door opener and exited the front door of the facility. -The survey team exited behind the resident through the open the doors. -Resident #8 followed the survey team out of the front doors, she crossed the front porch and went down the sidewalk to the corner. -She stood on the sidewalk facing the parking lot. Interview with Resident #8 on 06/09/26 at 9:40am revealed: -She did not know how long she had lived at the facility. -She knew she was in her room. -She had memory loss and could not answer questions. Interview with Resident #8 on 06/09/26 at 1:15pm revealed: -She did not know where she was going to go. -She did not know where she was. -She was following everyone outside.	D 067			

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D 067	Continued From page 3 -She had been outside before. Interview with a personal care aide (PCA) on 06/10/26 at 9:34am revealed: -Resident #8 was forgetful. -A couple of weeks ago, Resident #8 was complaining about not receiving her lunch after she had eaten it. -After five to ten minutes after mealtimes, Resident #8 would ask if she had eaten her meal. -Resident #8 could go outside unsupervised. Interview with another PCA on 06/10/26 at 9:40am revealed: -Resident #8 did was forgetful, she would say she did not receive her medication after they had been administered. -The medication aide (MA) would tell Resident #8 when her medication had been administered. -Resident #8 did not need to be supervised while outside because the resident would not elope. Interview with a MA on 06/10/26 at 11:14am revealed: -Resident #8 was not forgetful. -Resident #8 was only confused about where to put laundry. -He did not think Resident #8 needed to be supervised while outside. Interview with another MA on 06/11/26 at 9:38am revealed: -Resident #8 was a little forgetful. -Resident #8 did not need to be supervised while outside because she did not leave the porch. Interview with the Resident Care Coordinator (RCC) on 06/10/26 at 2:16pm revealed: -Resident #8 was sometimes forgetful. -She was aware Resident #8 was intermittently	D 067		

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D 067	Continued From page 4 disoriented. -Resident #8 would forget she had taken her medication and would ask staff for them 30 minutes later. -Resident #8 did not need to be supervised while outside. Interview with the Health and Wellness Coordinator (HWC) on 06/10/26 at 2:49pm revealed: -Resident #8 was sometimes confused and would ask the same questions twice. -Resident #8 was confused when there were big changes. -She was aware Resident #8 was intermittently disoriented. -Resident #8 could go outside unsupervised, because she was not at risk for elopement. Interview with the Health and Wellness Director (HWD) on 06/10/26 at 3:04pm revealed: -Resident #8 was sometimes forgetful and was mostly forgetful about the activities in the facility. -She could not recall which activities were scheduled after staff told her. -He was aware Resident #8 was intermittently disoriented. -Resident #8 could go outside without supervision and had not eloped from the facility. Interview with the Administrator on 06/10/26 at 3:34pm revealed: -Resident #8 was very forgetful on some days and on other days she was not. -She was aware Resident #8 was intermittently disoriented. -Resident #8 did not need to be supervised while outside. -Resident #8 had not eloped from the facility.	D 067		

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D 067	Continued From page 5 Attempted telephone interview with Resident #8's primary care provider (PCP) on 06/10/26 at 9:52am was unsuccessful. Refer to the interview with the Administrator on 06/10/26 at 3:34pm. 2. Review of Resident #2's FL2 dated 11/21/25 revealed: -Diagnoses included anxiety disorder, delirium, hypertension. -She was intermittently disoriented. Review of Resident #2's care plan dated 12/30/25 revealed she was forgetful. Interview with Resident #2 on 06/09/26 at 9:45am revealed: -She did not remember how long she had been at the facility. -She did not know the state where her son or daughter resided. -She stated she was forgetful. -She did not remember when she had moved to North Carolina. Interview with the medication aide (MA) on 06/10/26 at 3:36pm revealed: -Resident #2 was sometimes confused about which day of the week laundry was collected. -She would often ask the time of the day a meal was served. -Resident #2 only went outside to attend the flower garden and returned inside without cueing. Interview with a second MA on 06/11/26 at 9:08am revealed: -Resident #2 was forgetful. -She witnessed the resident several months ago, disoriented to place upon awakening.	D 067		

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D 067	Continued From page 6 Interview with a personal care aide (PCA) on 06/11/26 at 9:18am revealed Resident #2 required daily reminders to come to breakfast. Interview with Resident #2's family member on 06/11/26 at 9:49am revealed: -Resident #2 had dementia for 10 years and had short term memory loss. -She was not afraid Resident #2 would wander. -She was concerned and recognized that Resident #2's orientation could change at any time. -Resident #2 required reminders to shower. Interview with Health and Wellness Director (HWD) on 06/11/26 at 4:07pm revealed Resident #2 always walked indoors and there was no concern about wandering. Interview with the Administrator on 06/11/26 at 9:57am revealed Resident #2 was not confused and went to the store with the other residents and could purchase items and check out with the cashier without assistance. Refer to the interview with the Administrator on 06/10/26 at 3:34pm. Interview with the Administrator on 06/10/26 at 3:34pm revealed: -Residents signed in and out of the facility, but not when they were sitting on the porch. -She was not aware the facility needed to have a continuous sounding device if a resident was disoriented. The facility failed to ensure the alarms on the exit doors to the facility had a continuous and audible sounding device when the doors opened which	D 067		

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D 067	Continued From page 7 placed two residents who were intermittently disoriented (#7 and #8) at risk for elopement. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/09/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 26, 2026.	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 (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	D 195	Executive Director or designee will review staffing requirements and staffing assignments. Executive Director or designee will audit staffing assignments weekly for one (1) month. To assist with ongoing compliance, an audit of staffing assignments will be completed by the Executive Director or designee, monthly for six (6) months.	

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D 195	Continued From page 8 (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. <table border="0"> <thead> <tr> <th>Bed Count</th> <th>Position</th> <th>Type</th> <th>First Shift</th> <th>Second Shift</th> <th>Third Shift</th> </tr> </thead> <tbody> <tr> <td>21 - 30</td> <td>Aide</td> <td>16</td> <td>16</td> <td>8</td> <td></td> </tr> <tr> <td></td> <td>Supervisor</td> <td>Not Required</td> <td>Not Required</td> <td></td> <td></td> </tr> <tr> <td></td> <td>Administrator</td> <td>In the building, or within 500 feet and immediately available.</td> <td></td> <td></td> <td></td> </tr> <tr> <td>31-40</td> <td>Aide</td> <td>16</td> <td>16</td> <td>16</td> <td></td> </tr> <tr> <td></td> <td>Supervisor</td> <td>8*</td> <td>8*</td> <td>In the building, or within 500 feet and immediately available.**</td> <td></td> </tr> <tr> <td></td> <td>Administrator</td> <td>On call</td> <td></td> <td></td> <td></td> </tr> <tr> <td>41-50</td> <td>Aide</td> <td>20</td> <td>20</td> <td>16</td> <td></td> </tr> <tr> <td></td> <td>Supervisor</td> <td>8*</td> <td>8*</td> <td>In the building, or within 500 feet and immediately available.**</td> <td></td> </tr> <tr> <td></td> <td>Administrator</td> <td>On call</td> <td></td> <td></td> <td></td> </tr> <tr> <td>51-60</td> <td>Aide</td> <td>24</td> <td>24</td> <td>16</td> <td></td> </tr> <tr> <td></td> <td>Supervisor</td> <td>8*</td> <td>8*</td> <td>In the building, or within</td> <td></td> </tr> </tbody> </table>	Bed Count	Position	Type	First Shift	Second Shift	Third Shift	21 - 30	Aide	16	16	8			Supervisor	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		D 195		
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D 195	Continued From page 9 500 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. 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	D 195		

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D 195	Continued From page 10 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 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.	D 195		

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D 195	Continued From page 11 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, clearing used place settings from the tables, cleaning dining room tables, and cleaning the dining room floors. The findings are: Observations of the lunch meal on 06/09/26 from 12:00pm to 12:30pm revealed: -There was a personal care aide (PCA) serving the residents food, beverages and clearing the plates during the meal. -There was a manager in the dining room for part of the meal service. Observation of the lunch meal in the dining room on 06/10/26 from 11:48am to 12:28pm revealed: -As the residents entered the dining room the PCA served beverages plates. -As the residents finished their courses the PCA and the MA cleared the plates and beverages and served more courses. -The PCA cleared the plates and removed the tablecloths and placemats. Observation of the PCA and a medication aide (MA) on 06/11/26 at 9:30am revealed they were rolling silverware into cloth napkins for the meal service.	D 195			

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D 195	Continued From page 12 Interview with a PCA on 06/09/26 at 12:10pm revealed: -She set up the dining room and cleared the dishes after she served the residents their meals. -She did all the task in the dining room during the mealtimes without help from any other help from the kitchen staff. Interview with a second PCA on 06/11/26 at 10:45am revealed: -She rolled silverware into cloth napkin prior to each meal. -She put a roll of silverware and beverage glasses on the table before each meal. -She served the residents their meals during mealtimes. -After the meals she cleaned all the dishes off the tables and took them to the kitchen. -The kitchen staff washed the dishes. -She washed all the tablecloths, place mats and napkins after meals. -She swept the floor in the dining room after the meals. -She reset the tables with clean tablecloths and place mats for the next meal. -She would stop what she was doing and go help a resident if they needed anything and then come back to the dining room to finish. -There were about 30 residents in the dining room during meals. Interview with a MA on 06/11/26 at 10:00am revealed: -She would help the PCA in the dining room during mealtimes after she had administered medications. -She helped roll silverware and helped clear tables when she could. -There were usually 30 residents at a meal. -She and the PCAs had a good routine.	D 195		

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D 195	Continued From page 13 -If a resident needed personal care during a meal she would stop and attend to the resident. -She would have to stop and administer medications to the residents during meals. -Yesterday, 06/10/26, she had could not stop to administer a resident his medication so the hospice nurse administered it to him for her. Interview with the Health and Wellness Coordinator (HWC) on 06/11/26 at 11:00am revealed: -The MA and the PCAs helped to serve meals in the dining rooms. -When the meal starts everything else stops. -If a resident needed a medication during a meal service the MA would stop serving to administer the medication and the PCA would continue the service. -Residents' needs were still supposed to come first. -The PCAs rolled the silverware, set the tables, served the meals, cleared the tables, washed the linens and reset the tables for the next meal service. -If a resident needed help with personal care then the MA, or a manager would come into the dining room while the PCA was attending to the resident. -Each floor was staffed with one PCA and one MA. Interview with the Administrator on 06/11/26 at 11:45am revealed: -The facility had an additional MA everyday to help with resident care. -There was one PCA and one MA on each floor. -The MAs and the PCAs set the dining rooms, served and cleared the meals. -The managers were also available during meals to assist in the dining rooms.	D 195		

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D 195	Continued From page 14 -If a PCA needed to leave the dining room to provide care to a resident a manager would step into the dining room and help. -The MAs should stop what they were doing in the dining room and administer medications. -She thought the PCAs could help in the dining room as long as the facility staffed the second MA.	D 195		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to maintain a current listing of residents with physician ordered therapeutic diets for guidance of food service staff. The findings are: Review of the residents' diet orders on 06/09/26 revealed diets included a two gram (2gm) low sodium diet, a carbohydrate controlled diet, and a liberalized renal diet.	D 309	Dining Service Manager or designee will maintain a current listing of residents with physician ordered therapeutic diets for guidance of food service staff. Executive Director or designee will audit a current listing of residents with physician ordered therapeutic diets once a week for one (1) month. To assist with ongoing compliance, the HWD or designee will audit listing of residents with physician ordered therapeutic diets once a month for six (6) months.	

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D 309	Continued From page 15 Observation of the kitchen on 09/09/26 at 9:50am revealed: -There was a bulletin board with the diets the facility offered posted but there was no list of residents and their ordered therapeutic diets posted in the kitchen. -There was a therapeutic diet menu that included a 2gm low sodium diet, a carbohydrate controlled diet, and a liberalized renal diet. Interview with a cook on 06/09/26 at 1:10pm revealed: -He did not follow a diet list; he knew what the residents' diets were from memory. -The Dietary Manager let him know when a resident's diet order changed. Interview with a second cook on 06/09/26 at 9:20am revealed: -The personal care aides (PCA) took the residents' meal preferences each morning. -She thought the PCAs had a piece of paper with each resident's diet. -The Dietary Manager told her what the residents diets where. -None of the residents were on therapeutic diets. -There was a resident who could not have tomatoes or orange juice and they offered the residents who were diabetic sugar free beverages and desserts. Interview with a PCA on 06/11/26 at 10:45am revealed: -She served the residents' their meals. -She did not have a diet list she followed or looked at when she served the residents. -The kitchen staff told her to give certain plates to certain residents. -She knew the residents' diet orders and if she forgot she would aske the kitchen staff.	D 309		

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D 309	Continued From page 16 Interview with the Dietary Manager on 06/09/26 at 9:50am revealed: -The facility offered finger foods, pureed, texture modified, 2gm low sodium, no added salt, carbohydrate control and liberalized renal diet. -There was a resident on a 2gm low sodium diet and other diets but he could not recall the other diets. -There was not a list for the staff to follow. -There was a book with each residents' diet order on a shelf in the kitchen. -The kitchen staff and the cooks knew the residents' diets by memory. Interview with the Health and Wellness Coordinator (HWC) on 06/11/26 at 11:00am revealed: -Each resident had a physician signed diet order. -She printed the diet orders and after they were signed she gave them to the kitchen to place them in a binder for them to reference. -She also gave the kitchen a new diet list when there was a diet order change. -The diet list was accurate to the diets in the electronic system. Interview with the Administrator on 06/11/26 at 11:45am revealed: -The kitchen staff were given a new diet list when a diet order was changed. -The diet change was also verbally communicated with the kitchen. -The Dietary Manager was responsible for making sure the diet list was available for the cooks and the PCAs to reference for meals.	D 309		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications	D 375		

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D 375	Continued From page 17 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, interviews, and record reviews, the facility failed to ensure 3 of 3 sampled resident (#2, #5 and #10) had a physician's order to self-administer medications observed in the residents' rooms. The findings are: Review of the facility's Self-Administration of Medication policy dated 03/2026 revealed: -A resident who desired to self-manage medications must successfully complete the Self-Administration of Medications Review form, which would be completed by the Health and Wellness Director (HWD). -Once the resident successfully passed the Self-Administration of Medications Review form, the HWD would obtain an order allowing the resident to self-administer medications from the resident's Primary Care Provider (PCP).	D 375	Health and Wellness Director or designee will obtain physician's order to self – administer medications in the resident's room. HWD or designee will audit residents' room to identify any medications without an order, once a week for one (1) month. To assist with ongoing compliance, the HWD or designee will re- educate residents and their legal representatives on medication self-administration policies and will audit resident rooms for any medications without orders monthly for six (6) months.	

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D 375	Continued From page 18 -The resident would be assessed quarterly for the ability to safely self-administer medications. -This applied to over the counter and prescription medications. 1.Review of Resident #2's current FL2 dated 08/26/25 revealed: -Diagnoses included osteoarthritis and gait instability. -Resident #2 did not currently take any medications. -There was no order for self-administration of any medication. Observation of Resident #2's room on 06/09/26 at 9:08am revealed: -There was a bottle of extra strength acetaminophen-aspirin-caffeine (used to treat migraines) tablets sitting on the bathroom shelf. -There was a bottle hydrocortisone (a steroid) anti-itch liquid sitting on the bathroom shelf. -There was a bottle of antidiarrheal and upset stomach relief liquid sitting on the bathroom shelf. -There was a tube of zinc oxide (a skin protectant) cream sitting on the bathroom shelf. Review of Resident #2's electronic medication administration records (eMAR) for April and May 2026 revealed: -There was no entry for extra strength acetaminophen-aspirin-caffeine tablets. -There was no entry for hydrocortisone anti-itch liquid. -There was no entry for antidiarrheal and upset stomach relief liquid. -There was no entry for zinc oxide cream. Review of Resident #2's eMAR for June from 06/01/26-06/09/26 revealed: -There was no entry for extra strength	D 375			

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D 375	Continued From page 19 acetaminophen-aspirin-caffeine tablets. -There was no entry for hydrocortisone anti-itch liquid. -There was no entry for antidiarrheal and upset stomach relief liquid. -There was no entry for zinc oxide cream. Telephone interview with Resident #2's family member on 06/11/26 at 11:03am revealed: -All the over-the-counter medications in Resident #2's room were brought in by his wife. -The family members' wife did not realize Resident #2 needed an order to take over-the-counter medication. Attempted telephone interview with Resident #2's PCP on 06/10/26 at 9:56am was unsuccessful. Refer to the interview with the housekeeper on 06/11/26 at 9:15am. Refer to the interview with a personal care aide (PCA) on 06/11/26 at 9:25am. Refer to the interview with a medication aide (MA) on 06/11/26 at 9:35am Refer to the interview with the Health and Wellness Director (HWD) on 06/10/26 at 3:20pm. Refer to the interview with the Health and Wellness Coordinator (HWC) on 06/11/26 at 11:46am. Refer to the interview with the Executive Director on 06/11/26 at 12:27pm. 2.Review of Resident #5's current FL2 dated 02/25/26 revealed: -Diagnoses included candidiasis (fungal	D 375		

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D 375	Continued From page 20 infection). -There was no order for self-administration of any medication. Observation of Resident #5's room on 06/09/26 at 9:17am revealed: -There was a container of over-the-counter medicated powder sitting on a table with a prescription label dated 12/14/24. -On the container of medicated powder, "no order" was handwritten at the top. Review of Resident #5's electronic medication administration record (eMAR) for April and May 2026 revealed there was no entry for medicated powder. Review of Resident #5's eMAR for June 2026 from 06/01/26-06/09/26 revealed there was no entry for medicated powder. Interview with Resident #5 on 06/09/26 at 9:10am revealed: -She used the medicated powder when she had a flare of candidiasis (yeast). -She did not believe that she had an order to have the medicated powder in her room. -She did not think she needed an order to keep the medicated powder in her room because it could be purchased over-the-counter. -She did not know who wrote "no order" on the container of medicated powder. Attempted telephone interview with Resident #5's PCP on 06/10/26 at 9:56am was unsuccessful. Refer to the interview with the housekeeper on 06/11/26 at 9:15am. Refer to the interview with a personal care aide	D 375			

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D 375	Continued From page 21 (PCA) on 06/11/26 at 9:25am. Refer to the interview with a medication aide (MA) on 06/11/26 at 9:35am Refer to the interview with the Health and Wellness Director (HWD) on 06/10/26 at 3:20pm. Refer to the interview with the Health and Wellness Coordinator (HWC) on 06/11/26 at 11:46am. Refer to the interview with the Executive Director on 06/11/26 at 12:27pm. 3.Review of Resident #10's current FL2 dated 04/06/26 revealed: -Diagnoses included overactive bladder, coronary arterial disease and type 2 Diabetes. -There was no order to self-administer any medications. Observation of Resident #10's room on 06/09/26 at 8:37am revealed there were 2 bottles of lubricating eye drops sitting on a table next to his bed. Review of Resident #10's electronic medication administration record (eMAR) for April and May 2026 revealed there was no entry for lubricating eye drops. Review of Resident #10's eMAR for June 2026 from 06/01/26-06/09/26 revealed there was no entry for lubricating eye drops. Interview with Resident #10 on 06/09/26 at 8:42am revealed: -He used the eye drops before bed because he had dry eyes.	D 375	Health and Wellness Director a/or designee will obtain physician's order to self – administer medications in the resident's room. HWD and/ or designee will audit residents' room for any medications without the order once a week for a month. To help with ongoing compliance, HWD and/ or designee will re- educate the POA's and residents on self – administering policies and will audit residents' rooms for medications without orders once a month for 6 months.	

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D 375	Continued From page 22 -A family member purchased the eye drops for him. Interview with a medication aide (MA) on 06/11/26 at 9:40am revealed: -She had seen eye drops in Resident #10's room before. -She had removed the eye drops several times from Resident #10's room and called his family member. -She last removed the eye drops from Resident #10's room about 2 weeks ago. -She last talked to the family member about the eye drops about 1 week ago. -She told the family member that Resident #10 needed to have an order from his Primary Care Provider (PCP). -She did not reach out to Resident #10's PCP for an order. Attempted telephone interview with Resident #10's PCP on 06/10/26 at 9:56am was unsuccessful. Attempted telephone interview with Resident #10's family member on 06/11/26 at 12:40pm. Refer to the interview with the housekeeper on 06/11/26 at 9:15am. Refer to the interview with a personal care aide (PCA) on 06/11/26 at 9:25am. Refer to the interview with the Health and Wellness Director (HWD) on 06/10/26 at 3:20pm. Refer to the interview with the Health and Wellness Coordinator (HWC) on 06/11/26 at 11:46am.	D 375	Health and Wellness Director and/or designee will obtain physician's order to self – administer medications in the resident's room. HWD and/ or designee will audit residents' room for any medications without the order once a week for a month. To help with ongoing compliance, HWD and/ or designee will re- educate the POA's and residents on self – administering policies and will audit residents' rooms for medications without orders once a month for 6 months.	

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D 375	Continued From page 23 Refer to the interview with the Executive Director on 06/11/26 at 12:27pm. Interview with the Housekeeper on 06/11/26 at 9:15am revealed: -She knew if she saw any medications in the residents' room to notify the Health and Wellness Director (HWD) or Health and Wellness Coordinator (HWC). -She had not noticed any medications in the residents' rooms. Interview with a personal care aide (PCA) on 06/11/26 at 9:25am revealed she had not seen the over-the-counter medications in the residents' rooms; if she had, she would have notified the medication aide (MA). Interview with a MA on 06/11/26 at 9:35am revealed: -If she seen medication in a resident room, she would remove the medication and notify the HWD or HWC. -She had not noticed any medications in the residents' rooms. Interview with the HWC on 06/11/26 at 11:46am revealed: -The facility policy was to ensure residents that had medications in their room must have a completed self-administration assessment and have an order from their Primary Care Provider (PCP). -When the MA's notified her of medication in a resident's room, she would remove the medication and call the family to let them know about the self-administration policy. -She did not complete room sweeps checking for medications in the residents' rooms. -All residents and family members were notified	D 375			

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NAME OF PROVIDER OR SUPPLIER BROOKDALE CHAPEL HILL AL (NC)		STREET ADDRESS, CITY, STATE, ZIP CODE 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 375	Continued From page 24 of the self-administration policy prior to admitting to the facility. Interview with the HWD on 06/10/26 at 3:20pm revealed: -If any staff noticed medications in the residents' rooms, they were to notify the HWD or HWC. -He would then call the family and notify them the resident needed a Self-Administration assessment completed and an order from their PCP to keep the medications in their rooms. -All residents and their family members were notified prior to moving into the facility of the self-administration policy. -The facility staff did not complete room sweeps checking for medications in the residents' rooms. -Approximately every 6 months when he updated the residents' care plans, he would check for medications in the residents' room. Interview with the Executive Director (ED) on 06/11/26 at 12:27pm revealed: -If a resident had medication in their room, there should be an assessment and an order from the PCP to self-administer. -She was concerned that the resident could not take the medication correctly.	D 375		