STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(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) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 06/01/25 through 06/04/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1OM411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/01/25 through 06/04/25. Event ID# 1OM411. The following intakes were investigated NC00220466, NC00221184, NC00221534, and NC00222446. 2 of the 13 complaint allegations resulted in deficiency.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		6/23/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/20/2025

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain a packaged terminal air conditioner (PTAC) unit to prevent gaps at the installation site for 1 of 9 resident rooms (Room #309) on 1 of 2 halls observed for a clean, safe, comfortable, and homelike environment. The findings included: An observation of Room #309 on 6/2/25 at 10:06 am revealed the PTAC unit was dislodged from the wall on the right side. There were approximately 4 dime sized holes observed on the right side at the insertion site of the dislodged PTAC unit where the courtyard outside was viewed from inside Room #309.	F 584	FTAG 584 Safe/Clean/Comfortable/homelike environment. F-Tag: 584 Regulation: §483.10(i)(1) – The resident has a right to a safe, clean, comfortable, and homelike environment. Deficiency Summary: The facility failed to maintain a safe environment for residents by not ensuring that a PTAC unit was securely mounted to the wall in Resident Room 309 1. Corrective Action for Resident(s) Affected • The dislodged PTAC unit in Resident #1 in Room 309 was immediately secured and reinstalled by the facility's	

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F 584	Continued From page 2 A second observation of Room #309 was made on 6/2/25 at 2:30 pm and the PTAC unit remained dislodged from the wall on the right side. During an interview with the Maintenance Director on 6/3/25 at 9:00 am, he stated the staff informed him directly on any repairs needed throughout the facility, and the facility did not utilize a work order log book or have a book at the nurse's station to communicate with maintenance. He further stated he checked the PTAC units every 30 to 45 days for routine maintenance and/or when there was an issue reported. The Maintenance Director explained when the resident in Room #309 attempted to maneuver his wheelchair, he frequently hit the PTAC unit and that it may have caused the PTAC to become dislodged. He stated he was unaware of the 4 holes on the right side at the insertion site of the dislodged PTAC unit where the courtyard outside could be viewed from inside Room #309. The Maintenance Director further stated the outside shouldn't be seen while inside the room unless you were looking out of a window. In an interview with the Administrator on 6/3/25 at 12:15 pm she stated the Maintenance Director had informed her of the issues related to the dislodged PTAC unit in Room #309. The Administrator further stated the outside should not be visible through gaps around the PTAC while being in a resident's room. The Administrator's expectations were for repairs to be completed as soon as the maintenance department was made aware.	F 584	maintenance team on 06/05/2025 • The residents and/or their representatives were informed of the issue and the corrective action taken. 2. Identification of Other Residents Potentially Affected • A full inspection of all PTAC units in resident rooms and common areas was conducted to identify any other loose or improperly installed units on 06/06/2025 • No additional units were found to be dislodged, but minor maintenance adjustments were made on any units that showed signs of wear. 3. Measures and Systemic Changes to Prevent Recurrence • The maintenance staff were re-educated on inspection and mounting standards for PTAC units per manufacturer specifications and facility policy on 06/06/2025. • A checklist was developed for quarterly inspection of all PTAC units, including securing brackets, seals, and overall structural integrity. • Facility policy for room maintenance was revised to include documentation of all heating and cooling system checks. 4. Monitoring and Quality Assurance • The Maintenance Director will conduct monthly random audits of 10 resident rooms to verify the structural security of PTAC units for the next 3 months. • Audit results will be reviewed during the monthly QAPI committee meetings. • If any issues are identified during ongoing inspections, immediate corrective actions will be taken and documented.	

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F 584	Continued From page 3	F 584	5. Date of Completion: 08/15/2025	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code mood for 1 of 18 Minimum Data Set (MDS) assessments reviewed (Resident #32).	F 641	F-Tag: 641 Regulation: §483.20(g) – Each assessment must accurately reflect the resident's status.	6/23/25

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F 641	Continued From page 4 The findings included: Resident #32 was admitted to the facility on 5/15/23 with diagnoses including mood disorder. Resident #32's annual Minimum Data Set (MDS) assessment dated 4/30/25 revealed she was rarely/never understood, and a staff assessment for mood should be conducted but was not. During an interview with the facility Social Worker on 6/3/25 at 4:17 PM she stated she was responsible for conducting the mood section on Resident #32's MDS assessment. She further stated if a resident was not interviewable a staff assessment should have been completed. The Social Worker stated it was not done, and it was an oversight. An interview was conducted with the Administrator on 6/4/25 at 12:29 PM who stated staff should have completed the assessment for mood to correctly complete Resident #32's MDS assessment.	F 641	Deficiency Summary: The facility failed to accurately code Section D (Mood) of the MDS for [X] out of [Y] sampled residents. Specifically, PHQ-9 responses were inaccurately recorded, leading to an underreporting of depressive symptoms. 1. Corrective Action Taken for Resident(s) Affected • Section D of the MDS for the identified resident # 32 was immediately reviewed and corrected using resident interviews, nursing documentation, and psychiatric consults. • The interdisciplinary team (IDT) was notified, and care plans were updated to reflect accurate mood status and necessary interventions. • A referral was placed for further mental health evaluation where appropriate. 2. Identification of Other Residents with the Potential to Be Affected • An audit of all completed MDS assessments from the last 30 days that included Section D was conducted on 06/06/2025 by Administrator/Designee. • Any discrepancies in PHQ-9 or staff assessment interview responses were corrected and documented. • Residents identified with previously undocumented symptoms were referred for follow-up, and care plans were updated accordingly. 3. Systemic Changes to Prevent Recurrence • MDS nurse and social worker were re-educated on accurate coding procedures for Section D, including proper	

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F 641	Continued From page 5	F 641	interview techniques for the PHQ-9 and the Staff Assessment of Mood. • Interview training included the importance of asking each question as written, allowing residents time to respond, and recording answers as reported—not interpreted. • The facility revised its MDS accuracy protocol to require a second staff member (charge nurse/MDS nurse to verify Section D responses before final submission. • The IDT now reviews mood assessments at care plan meetings to ensure consistency with resident reports and documentation. 4. Monitoring to Ensure Compliance • The DON or designee will audit 5 MDS assessments per week (focusing on Section D) for 12 weeks using a Section D audit tool. • Any error rates over 5% will trigger additional education and ongoing weekly audits. • Results will be reviewed during monthly QAPI meetings to ensure continued compliance. 5. Date of Completion: __08/15/2025_____	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		6/20/25

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F 689	Continued From page 6 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to equip 1 of 1 designated resident smoking area with a fire extinguisher and fire blanket. The findings included: The designated resident smoking area was observed on 6/2/25 at 3:00 pm. The designated resident smoking area was located in the courtyard and had an approximate 10 by 10 feet of covered patio on a concrete pad with an approximate 15-inch brick border. The resident designated smoking area contained 3 red metal self-closing trash containers approximately 11 inches in diameter by 15 inches tall in size and 4 round metal tables with 3 to 4 metal chairs at each table. On each table were a minimum of 2 ashtrays, and a large beige cylindrical plastic trash receptacle was next to one of the tables . No fire extinguisher or fire blanket was observed. On 6/3/25 at 12:24 pm, one resident and two staff members were observed smoking in the designated resident smoking area. No fire extinguisher or fire blanket was observed. During an interview with the Administrator on 6/4/25 at 12:45 pm, she stated the designated smoking area was for residents and staff members. The Administrator indicated the residents who smoked were assessed as independent safe smokers. She further stated	F 689	Citation Summary: The facility failed to ensure resident safety by not maintaining the required fire safety equipment—a fire extinguishers or smoke blanketing the designated smoking area. 1. Corrective Action for Residents Affected by Deficient Practice. • Immediately upon identification, a smoke blanket was installed in the smoking area. • All residents who utilize the smoking area were reassessed for safety risks and re-educated on facility smoking policies. 2. Identification of Other Residents Who May Be Affected. • A review of all residents authorized to smoke was completed. • Observational audits of the smoking area and related supervision procedures were conducted to ensure safety protocols are in place for all residents using the area. • No other residents were identified as harmed, but all were potentially at risk due to the missing equipment. 3. Systemic Changes to Prevent Reoccurrence • Facility smoking policy was reviewed and revised to include: • Mandatory presence and	

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F 689	Continued From page 7 she was unaware that she was required to have a fire extinguisher and fire blanket. The Administrator explained she would have her Maintenance Director put a fire extinguisher/fire blanket in the designated smoking area as soon as possible.	F 689	documentation of fire safety equipment in designated smoking areas. • Daily safety checks of the smoking area by maintenance and/or nursing staff. 4. Monitoring and Quality Assurance The Administrator or designee will audit the smoking area 3 times per week for 4 weeks, then monthly for 3 months to ensure: • Smoke blanket is clean, intact, and accessible. • No smoking occurs unless safety equipment is present. Audit will be complete by 8/15/2025 Results will be reported to the QAPI committee monthly for review and further action as needed.	