| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **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 |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on 12/13/23 and 12/14/23. | D 000 | | |
| D 234 | 10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio<br><br>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations<br>(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 Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#4) were tested for Tuberculosis (TB) disease in compliance with the guidelines from the Commission for Public Health.<br><br>The findings are:<br><br>Review of Resident #4's current FL-2 dated 10/05/23 revealed diagnoses that included chronic kidney disease, hypothyroidism, heart failure, dyslipidemia and history of breast and uterine cancer.<br><br>Review of Resident #4's Resident Register revealed she was admitted to the facility on 11/07/23. | D 234 | | |

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| D 234 | Continued From page 1<br><br>Review of Resident #4's record revealed:<br>-There was no record of a TB screening evaluation done.<br>-There was record of a chest x-ray done in June 2023 for a cough.<br><br>Interview with Resident #4 on 12/14/23 at 3:00pm revealed she did not receive a TB screening evaluation when she was admitted to the facility or since being admitted.<br><br>Interview with the Resident Care Director (RCD) on 12/14/23 at 1:50pm revealed:<br>-Resident #4 was admitted to the facility in November 2023.<br>-Resident #4 did not have a TB screening evaluation done on admission.<br>-Resident #4 had a chest x-ray done in June 2023.<br>-She had no knowledge of Resident #4 having a previous positive skin test.<br>-She was responsible for ensuring the facility nurse knew when new admissions required TB screening.<br>-She did not let the nurse know to complete TB screening for Resident #4.<br>-She thought a chest x-ray could be done instead of the skin test.<br><br>Interview with the Administrator on 12/14/23 at 10:34am revealed her expectation was that residents receive TB screening prior to or on admission but she was under the impression that a chest x-ray was acceptable. | D 234 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up | D 273 | | |

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| D 273 | Continued From page 2 | D 273 | | |

to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to ensure physician follow up was completed for 1 of 5 sampled residents (#5) who had heart rate (HR) values outside of the ordered parameter.

The findings are:

Review of Resident #5's current FL2 dated 06/21/23 revealed diagnoses included dementia, hearing loss, and hypertension.

Review of Resident #5's physician's order dated 11/20/23 revealed there was an order to check Resident #5's blood pressure (BP) and HR daily for two weeks and to notify the primary care provider (PCP) if the BP was greater than 170/100 or less than 90/60 or if the HR was less than 60.

Review of Resident #5's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for check blood pressure daily for two weeks and call medical doctor (MD) for a BP greater than 170/100 or less than 90/60 or if HR less than 60 scheduled daily at 8:00am.
-On 11/24/23, Resident #5's HR was 50; there was no documentation the PCP was notified.
-On 11/27/23, Resident #5's HR was 46; there was no documentation the PCP was notified.
-On 11/28/23, Resident #5's HR was 43; there was no documentation the PCP was notified.
-On 11/29/23, Resident #5's HR was 48; there was no documentation the PCP was notified.
-On 11/30/23, Resident #5's HR was 45; there

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was no documentation the PCP was notified.
-From 11/23/23 through 11/30/23, Resident #5's HR ranged from 43 to 76.

Review of Resident #5's December 2023 eMAR revealed:
-There was an entry for check blood pressure daily for two weeks and call medical doctor (MD) for a BP greater than 170/100 or less than 90/60 or if HR less than 60 scheduled daily at 8:00am.
-On 12/02/23, Resident #5's HR was 42; there was no documentation the PCP was notified.
-On 12/03/23, Resident #5's HR was 49; there was no documentation the PCP was notified.
-On 12/05/23, Resident #5's HR was 54; there was no documentation the PCP was notified.
-On 12/06/23, Resident #5's HR was 50; there was no documentation the PCP was notified.
-From 12/01/23 through 12/06/23, Resident #5's HR ranged from 42 to 86.

Review of Resident #5's progress notes revealed there was no documentation that the PCP had been notified of HR values less than 60 for November 2023 and December 2023.

Based on observations, interviews, and record review, it was determined Resident #5 was not interviewable.

Telephone interview with Resident #5's PCP on 12/14/23 at 11:32am revealed:
-She was Resident #5's PCP as of 11/20/23.
-She had not received any notifications about Resident #5's HR being outside of the ordered parameter.
-She had written the order to check Resident #5's BP and HR daily because Resident #5 was previously having high blood pressures.
-She had not seen Resident #5 since 11/20/23,

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but was scheduled to see Resident #5 next week.
-She may have lowered Resident #5's dose of metoprolol (a medication used to treat high blood pressure) if she had been notified of Resident #5's low HR values.

Interview with the medication aide (MA) on 12/14/23 at 1:48pm revealed:
-She knew there was an order to notify Resident #5's PCP if Resident #5's HR was outside the ordered parameter.
-She notified Resident #5's PCP that Resident #5's HR was low.
-She notified the Resident Care Director (RCD) that Resident #5's HR was outside the ordered parameter for 9 of 14 days in November and December 2023.
-Resident #5 had a new PCP as of 11/20/23 and MAs were unable to directly contact the PCP.
-MAs were able to notify Resident #5's previous PCP of vital signs outside of ordered parameters via fax, but were now unable to do so.
-MAs sometimes wrote values outside of ordered parameters on a physician's notification sheet and the PCP would review the sheets when they came to the facility.

Interview with the RCD on 12/14/23 at 1:55pm revealed:
-The residents and facility had a new PCP as of a few weeks ago and MAs could not directly contact the new PCP to notify of vital signs outside of ordered parameters.
-MAs were able to contact and notify the new PCP indirectly through the PCP's employer.
-MAs could let her know if a resident had vital signs outside of ordered parameters and she would be able to directly notify the PCP.
-She did not know that Resident #5's HR was outside of the PCP's ordered parameters for 9 of

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| D 273 | Continued From page 5<br>14 days until 12/14/23.<br>-She routinely printed out the residents' vital sign sheets when the PCP visited the facility and reviewed the vital signs with the PCP.<br>-She expected MAs to run a vital signs report, review the residents' vital signs and to let her know if a resident's HR was outside the parameter.<br>-The MAs knew to inform her if residents' vital signs were abnormal.<br>-The MAs normally informed her if a resident's heart rate or blood pressure were outside of ordered parameters.<br>-There was no documentation that Resident #5's PCP was notified of Resident #5's HR below the ordered parameter until 12/14/23.<br><br>Interview with the Administrator on 12/14/23 at 2:30pm revealed:<br>-She started working at the facility last week.<br>-She did not know that Resident #5's HR was outside the ordered parameters for 9 of 14 days from 11/23/23 to 12/06/23 until 12/14/23.<br>-She would have expected there to be a system in place for MAs to notify the PCP of vital signs outside of ordered parameters.<br>-There was currently no system in place for MAs to directly contact the PCP or a way for MAs to document and leave documentation for the RCD to review if vital signs were abnormal when the RCD was not at the facility.<br>-MAs were responsible to initiate notifying the provider of vital signs outside of ordered parameters and to report abnormal vital signs to the RCD. | D 273 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration | D 358 | | |

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10A NCAC 13F .1004 Medication Administration
(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#1) who had a medication ordered to treat diabetes.

The findings are:

Review of Resident #1's current FL-2 dated 09/20/23 revealed:
-Diagnoses included diabetes mellitus type 2, hypertension, hyperlipidemia, diabetic neuropathy and below the knee amputation.
-There was an order for Ozempic 0.25milligrams (mg), give 0.5 mg weekly on Sunday.

Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Ozempic 0.25-0.5mg/dose pen inject 0.5mg once weekly on Sunday with an administration time of 8:00am.
-There was documentation Ozempic 0.5mg was administered on 10/8/23, 10/15/23, and 10/29/23.
-On 10/22/23, the Ozempic 0.5 mg was circled as not given. The documentation included the reason as not administered was "not in house".
-Finger stick blood sugar (FSBS) checks were documented daily with results from 75-162.

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Review of Resident #1's November 2023 eMAR revealed:
-There was an entry for Ozempic 0.25-0.5mg/dose pen inject 0.5mg once weekly on Sunday with an administration time of 8:00am.
-There was documentation Ozempic 0.5mg was administered on 11/05/23, 11/12/23, and 11/26/23.
-There was documentation Ozempic 0.5mg was not administered. The reason documented was "resident unable to take".
-FSBS checks were documented daily with results from 57-140.

Review of Resident #1's December 2023 eMAR for December 1, 2023 to December 14, 2023 revealed:
-There was an entry for Ozempic 0.25-0.5mg/dose pen inject 0.5mg once weekly on Sunday with an administration time of 8:00am.
-There was documentation Ozempic 0.5mg was administered on 12/03/23 and 12/10/23.
-FSBS checks were documented daily with results from 82-132.

Observation of Resident #1's medications on hand on 12/13/23 at 3:00pm revealed there was an empty Ozempic dose pen in the medication cart.

Observation of Resident #1's medications on hand on 12/14/23 at 11:30am revealed there was a sealed box of Ozempic with a dispense date of 10/16/23 for four doses.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 12/14/23 at 9:50am revealed:
-There was an active order for Ozempic 0.5mg to

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be administered weekly on Sunday.
-The pharmacy dispensed one Ozempic pen that contained four doses on 08/21/23, 09/18/23 and 10/16/23.
-The facility had not requested Ozempic to be refilled after the most recent dispensed supply on 10/16/23.

Interview with Resident #1 on 12/14/23 at 10:15am revealed:
-She took Ozempic weekly on Sunday for her diabetes.
-She thought she may have missed a couple of doses.

Interview with a medication aide (MA) on 12/13/23 at 3:00pm revealed:
-Resident #1 received Ozempic 0.5mg weekly on Sunday.
-She worked every other Sunday and administered the Ozempic when she worked.
-She re-ordered the Ozempic a week in advance and also followed up with a phone call to the pharmacy.
-She stated the Ozempic pen on the medication cart was empty but there was more Ozempic in the refrigerator.
-She did not know why the Ozempic was documented as not available on 10/22/23 as it was in the facility in the refrigerator.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 12/14/23 at 11:33am revealed:
-She was new to the facility and saw Resident #1 one time on 11/27/23.
-Resident #1 was prescribed Ozempic 0.5mg on Sunday for diabetes.
-Resident #1 was also prescribed Lantus that was administered at night.

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-Resident #1's blood sugars were well controlled.
-She expected medications to be administered as ordered.

Second interview with the MA on 12/14/23 at 10:00am revealed:
-The Ozempic available in the refrigerator that was dispensed on 10/16/23 was still sealed.
-She did not know why the Ozempic pen was not on the medication cart for use.
-She thought some MAs might not know the Ozempic was in the refrigerator.
-She could not explain how the Ozempic was documented as given on 10/29/23, 11/05/23, 11/12/23, 11/26/23, 12/03/23 and 12/10/23 when the medication was unopened in the refrigerator.

Interview with the Resident Care Director (RCD) on 12/14/23 at 1:50pm revealed:
-Resident #1 was ordered Ozempic 0.5mg weekly.
-MAs would have to re-order the Ozempic using the eMAR system.
-MAs were aware the Ozempic was in the refrigerator.
-She did not know why the Ozempic pen that was dispensed on 10/16/23 was still unopened in the refrigerator.
-She believed the MAs did administer the Ozempic as ordered but could not explain how it was being administered when there was no Ozempic on the medication cart and the Ozempic available in the refrigerator was unopened.

Interview with the Administrator on 12/14/23 at 2:10pm revealed:
-She was new to the facility and was not aware Resident #1 received Ozempic.
-She would expect MAs to reorder medication when there were 7 days of medication left.

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| D 358 | Continued From page 10<br>-Currently there were no medication cart audits being done.<br>-She would expect medications to be administered as ordered. | D 358 | | |