STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018016	A. BUILDING: _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HICKORY NORTHEAST	2530 16TH STREET N E HICKORY, NC 28601

(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 and the Catawba County Department of Social Services conducted an annual survey on April 29, 2025-April 30, 2025.	D 000		
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 review and interviews the facility failed to ensure 1 of 5 sampled residents (Resident #4) were tested for tuberculosis (TB) disease in compliance with the control measures for the Commission for Control Measures. The findings are: Review of Resident #4's current FL2 dated 01/23/25 diagnoses included chronic obstructive pulmonary disease, respiratory failure, chronic kidney disease, atrial fibrillation, diabetes, and chronic anticoagulation. Review of Resident #4's Resident Register	D 234		

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D 234	Continued From page 1 revealed an admission date of 03/23/23. Review of Resident #4's record revealed: -There was no documentation of TB testing within ninety days of Resident #4's admission to the facility. -There was documentation Resident #4 had tuberculosis testing on 12/3/22 and the result was negative. Interview with Resident #4 on 04/30/25 at 11:30am revealed she could not recall if or when she was administered a TB test prior to her admission date of 03/23/23. Interview with the Health & Wellness director on 4/20/25 at 12:50pm revealed: -The TB record she located for Resident #4 was dated 12/3/22 from a previous stay at a rehabilitation center. -There was no documentation of TB testing for Resident #4, within ninety days of her admission to the facility. -She was not aware of the current process for auditing charts of previous admissions to ensure all necessary documents were included in resident records. -She expected TB testing to be completed within ninety days prior to a resident being admitted. Interview with the Administrator on 04/30/25 at 1:45pm revealed: -Resident #4 was admitted before the current administration and she did not know why Resident #4 did not have an updated TB test prior to being admitted to the facility. -The current admissions, sales/ marketing department and the Health & Wellness Director were responsible for obtaining necessary admission paperwork (including TB testing)	D 234		

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D 234	Continued From page 2 before residents were admitted to the facility. -She expected all prospective residents to have a TB test prior to their accepted admission to the facility.	D 234		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure the Medication Administration Records (MAR) were accurate for 1 of 5 sampled residents (Resident #4) related to inaccurate documentation of a medication used to treat	D 367		

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D 367	Continued From page 3	D 367		

pulmonary disease.

The findings are:

Review of Resident #4's current FL2 dated 01/23/25 diagnoses of chronic obstructive pulmonary disease, respiratory failure, chronic kidney disease, atrial fibrillation, diabetes, and chronic anticoagulation.

Review of Resident #4's Resident Register revealed an admission date of 03/23/23.

Review of Resident #4's record revealed a physician's order dated 04/08/25 for prednisone 20mg, take 2 tablets every day by mouth for 5 days.

Review of Resident #4's electronic Medication Administration Record (eMAR) for April 2025 revealed:
-There was an entry for prednisone 20mg, one tablet by mouth 2 times per day for allergic reaction. There was no end date on the entry.
-There was documentation of prednisone 20 mg tablets were administered 11 days (04/9/25 to 04/15/25, 04/17/25, 04/18/25, 04/21/25, and 04/23/25.)
- There was documentation that prednisone 20mg tablets were not administered on 04/16/25, 04/19/25, 04/20/25, 04/22/25 and 04/24/25 to 04/26/25 due to "resident's 5 days are done, no more tablets on the cart" per eMAR note.
-There was documentation that prednisone 20mg tablets were discontinued on 04/26/25.

Observation of Resident #4's medications available for administration on 04/30/25 revealed Resident #4 did not have any remaining prednisone 20mg tablets.

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D 367	Continued From page 4 Interview with the facility's contracted pharmacist consultant on 04/30/25 at 12:00pm revealed: -The pharmacy received an order for and dispensed prednisone 20mg, 2 tabs by mouth every day for 5 days for Resident #4. -The pharmacy dispensed 10 tablets of prednisone 20mg for Resident #4 on 04/08/25 to the facility. Interview with the Resident Care Coordinator (RCC) on 04/30/25 revealed: -Resident #4's order for prednisone 20mg, 2 tablets every day for 5 days, was written by an outside provider and was faxed directly to the pharmacy. -Resident #4 may not have returned with paperwork from her appointment with the outside provider that would have included the original prescription for prednisone. -She did not know why the prednisone order was entered on the eMAR incorrectly, with no end date of 5 days. -She did not know why documentation was entered as the prednisone was "administered" (04/13/25 to 04/15/25, 04/17/25 to 04/18/25, 04/21/25 and 04/23/25) when there were no remaining tablets on the medication cart. -The Medication Aide (MA) who entered the incorrect documentation "as administered", no longer works at the facility. -The RCC and Health and Wellness Director (HDW) were responsible for checking behind each other when auditing medications. Interview with the HWD on 04/30/25 at 12:50pm revealed: -She was responsible for entering orders received from the provider, on the eMAR. -The HWD and the RCC conducted monthly chart and cart audits.	D 367		

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D 367	Continued From page 5 -MAs were responsible for notifying the HWD of missing medications or discrepancies on the eMAR or medication cart. -She did not know why an end date was omitted when the Resident #4's prednisone order was entered on the eMAR. -She expected the RCC to act as a second pair of eyes to ensure all orders were correct. Interview with the Administrator on 04/30/25 at 1:45pm revealed: -She worked the cart on the weekend of 04/26/25 and caught the discrepancy related to Resident #4's prednisone that did not have an end date on the eMAR. -The RCC and HWD were responsible for reviewing and double-checking orders. -The MA who documented she administrated prednisone to Resident #4 when there were no more tablets, no longer works at the facility. -She expected orders received from providers to be accurately entered and double checked before being entered on the eMAR. -She expected MAs to notify the HWD or RCC if there was a discrepancy on the eMAR or med cart.	D 367		