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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on July 23 - 24, 2024.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 7 sampled staff (E, F, G) completed the state approved medication aide training (Staff F and G) and medication clinical skills validation (Staff E and F). The findings are: 1. Review of Staff E's personnel record revealed: -She was hired on 11/11/22 as a medication aide (MA). -There was no documentation that the medication clinical skills validation was completed. Interview with Staff E on 07/24/24 at 3:19pm revealed: -She completed her clinical skills validation with a nurse.	D 125		

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D 125	Continued From page 1 -She was not sure of the date she completed her medication clinical skills validation. Refer to interview with the Administrator on 07/24/24 at 2:32pm. 2. Review of Staff F's personnel record revealed: -She was hired on 04/23/24 as a medication aide (MA). -There was no documentation that the medication clinical skills validation was completed. -There was no documentation that the state approved 5-, 10-, or 15-hour medication training was completed. Refer to interview with the Administrator on 07/24/24 at 2:32pm. 3. Review of Staff G's personnel record revealed: -She was hired on 06/19/24 as a medication aide (MA). -There was no documentation that the state approved 5-, 10-, or 15-hour medication training was completed. Interview with Staff G on 07/24/24 at 2:28pm revealed: -She completed her 5- and 10-hour training online. -She was not sure of the date she completed the training. Refer to interview with the Administrator on 07/24/24 at 2:32pm. _____ Interview with the Administrator on 07/24/24 at 2:32pm revealed: -She started working with the facility in May 2024. -She was aware the medication aides (MAs) were	D 125		

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D 125	Continued From page 2 not able to administer medications until the 5-hour training and medication clinical skills validation were completed. -She had not completed an audit of the personnel files for the MAs to ensure the state approved medication training and medication clinical skills validation were completed. -It was the responsibility of the Administrator, Business Office Coordinator, Health and Wellness Director and the Resident Care Coordinator (RCC) to ensure the state approved 5-, 10-, or 15-hour medication training and the medication clinical skills validation for the MAs were completed. -She was not aware Staff E, F, and G were missing the state approved medication training and/ or the medication clinical skills validation.	D 125		
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 interviews and record reviews, the facility failed to ensure 1 of 5 residents (#5)	D 234		

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sampled was tested for tuberculosis (TB) disease upon admission.

The findings are:

Review of Resident #5's current FL-2 dated 06/04/24 revealed diagnoses included depression, hypothyroidism, hyperlipidemia, anxiety disorder, essential primary hypertension, age-related osteoporosis, fibromyalgia, and osteoarthritis.

Review of Resident #5's Resident Register revealed:
-The resident's date of admission was 07/05/22.
-The resident was admitted to the facility from a rehabilitation facility in another state.

Review of Resident #5's computer printed Immunization Report revealed:
-There was documentation a tuberculosis (TB) skin test was administered on 05/03/22 and the results were 0mm (negative).
-There was no documentation of who placed or read the TB skin test and no documentation of the date the TB skin test was read.
-There was no documentation of any other TB skin tests for the resident.

Interview with Resident #5 on 07/24/24 at 3:52pm revealed:
-She recalled having TB skin tests several years ago when she was younger, and they were always negative.
-She did not recall having any TB skin tests prior to being admitted to the facility in 2022.

Interview with the Health and Wellness Director (HWD) on 07/24/24 at 4:15pm revealed:
-She was responsible for ensuring the required

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D 234	Continued From page 4 TB skin tests were completed for residents upon admission to the facility. -She started working at the facility in October 2023, after Resident #5 was admitted in 2022. -She was not aware Resident #5 did not have the required TB skin testing on file. -She was in the process of reviewing residents' records for compliance, but she had not completed that process.	D 234		
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 interviews and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#5) related to not scheduling a referral for a gastroenterology provider for a resident with swallowing difficulties. The findings are: Review of Resident #5's current FL-2 dated 06/04/24 revealed diagnoses included depression, hypothyroidism, hyperlipidemia, anxiety disorder, essential primary hypertension, age-related osteoporosis, fibromyalgia, and osteoarthritis. Review of Resident #5's facility progress notes dated 02/29/24 at 12:55pm revealed: -During lunch, the resident had a choking episode. -Staff took the resident to her room, where she was able to cough up mucus and food and clear	D 273		

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her passageway.
-Staff would continue to monitor the resident.

Review of Resident #5's primary care provider (PCP) visit note dated 04/04/24 revealed the PCP ordered a gastroenterology provider referral for esophageal stenosis (narrowing of the esophagus, making it difficult to swallow).

Review of Resident #5's facility progress notes dated 04/17/24 at 11:25pm revealed:
-The resident choked on a sandwich at dinner today.
-Cardio-pulmonary resuscitation (CPR) was not needed.
-The medication aide (MA) was able to check on the resident and the resident had no complaints or concerns.

Review of Resident #5's facility progress notes dated 06/12/24 at 1:19pm revealed:
-The resident was eating lunch and began to choke.
-The resident stated she choked on the green peas.

Review of Resident #5's PCP order dated 06/13/24 revealed an order for speech therapy (ST) because the resident had difficulty swallowing food.

Review of Resident #5's ST visit note dated 06/24/24 revealed the speech therapist recommended a referral to a gastroenterology provider due to the resident's history of esophageal issues.

Review of Resident #5's provider visit notes for April 2024 - July 2024 revealed there was no documentation of the resident being seen by a

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D 273	Continued From page 6 gastroenterology provider as ordered. Interview with Resident #5 on 07/24/24 at 3:52pm revealed: -She had been having swallowing problems in the last year. -She recalled seeing a speech therapist who told her it would be a good idea to see a gastroenterology provider. -She had not seen a gastroenterology provider and she did not have an appointment to see one to her knowledge. -She felt like she needed to see a gastroenterology provider since her throat was dry and she had swallowing problems. Telephone interview with a front desk attendant for Resident #5's gastroenterology provider's office on 07/25/24 at 10:59am revealed: -They did not have Resident #5 in their computer system and the resident had never been seen by a provider at their office. -There was currently no appointment scheduled in the system for Resident #5. Interview with the Resident Care Coordinator (RCC) on 07/24/24 at 4:45pm revealed: -She was responsible for setting up referrals for residents, including calling and making the appointments and writing the appointments on a reminder board. -Resident #5's gastroenterology referral ordered by the PCP in April 2024 was not done because she overlooked the referral order. -She also overlooked the recommendation from ST for the resident to be seen by a gastroenterology provider. -She contacted the gastroenterology provider's office yesterday, 07/23/24 and she was waiting for them to call back with an appointment date	D 273		

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D 273	Continued From page 7 and time. Interview with the Health and Wellness Director (HWD) on 07/24/24 at 4:58pm revealed: -She assisted the RCC with referrals. -There had not been enough time with all of her other duties to check all residents' referrals and follow-ups. Interview with the Administrator on 07/24/24 at 5:02pm revealed: -The RCC and HWD were responsible for implementing referrals, including making the appointments for the referrals. -Resident #5 should have seen a gastroenterology provider as ordered. Telephone interview with Resident #5's PCP on 07/24/24 at 5:54pm revealed: -He ordered the gastroenterology referral for Resident #5 because of the resident's history of esophageal issues to make sure to "cover all bases". -He was not aware Resident #5 had not been seen by a gastroenterology provider yet. -He still wanted Resident #5 to be seen by a gastroenterology provider. -He did not have any immediate concerns about the delay in the resident seeing a gastroenterology provider because it was not an urgent request.	D 273		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the	D 366		

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staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) who prepared and administered medication was the MA who actually documented the administration of medication immediately following the administration and observation of the residents actually taking the medications for 2 of 4 residents (#5, #9) observed on the 300 hall during the morning medication pass on 07/24/24.

The findings are:

Observation of the 300 hall on 07/24/24 at 8:52am revealed a first shift medication aide (MA) was standing at the medication cart on 300 hall.

Interview with the first shift MA on 07/24/24 at 8:52am revealed:
-She was late getting to work today, 07/24/24, so a third shift MA administered medications on the 300 hall until she took over.
-She had 2 residents on the 300 hall left to administer medications to for the morning medications pass.

Observation of Resident #5 on 07/24/24 at 8:54am revealed:
-Resident #5 was in bed in her room.
-The third shift MA was in the resident's room administering medications to the resident.

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D 366	Continued From page 9 Interview with the first shift MA on 07/24/24 at 8:55am revealed: -Resident #5 was the last resident that the third shift MA was administering medications to that morning. -The third shift MA had signed the administration of medications in the electronic medication administration record (eMAR) for Resident #5 already, before the third shift MA went to the room to administer the medications. -The third shift MA was currently signed out of the computer eMAR system and she was signed into the eMAR system. Observation of the 300 hall on 07/24/24 at 8:57am revealed: -The third shift MA came out of Resident #5's holding a water cup and an empty medication cup and went to the medication cart. -The third shift MA told the first shift MA that she had "already signed mine". Review of Resident #5's July 2024 eMAR revealed the resident's oral medications scheduled for 9:00am had been initialed by the third shift MA. Interview with the third shift MA on 07/24/24 at 9:16am revealed she was helping the first shift MA and had already signed the eMAR before she administered medications to Resident #5. Observation of the 300 hall on 07/24/24 at 9:04am revealed: -The third shift MA came from the medication cart down the hall holding a medication cup with pills and a cup with water. -The first shift MA was standing at the 300 hall medication cart that the third shift MA had walked away from.	D 366		

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D 366	Continued From page 10 Interview with the first shift MA on 07/24/24 at 9:04am revealed she had prepared the medications for Resident #9 and the third shift MA was taking the medications to administer to the resident. Interview with the third shift MA on 07/24/24 at 9:04am revealed: -She was helping the first shift MA out by delivering the medications prepared by the first shift MA to Resident #9. -She was not signed into the eMAR system so the eMAR would show the first shift MA's initials as the person who administered the medications. -She was not aware of a way both MAs could document on the eMAR, one for preparation and one for administration. Observation of the third shift MA on 07/24/24 at 9:04am, the third shift MA took the prepared medications back to the first shift MA at the medication cart after intervention by surveyor. Observation of the first shift MA on 07/24/24 at 9:25am revealed she administered the medications to Resident #9. Review of Resident #9's July 2024 eMAR revealed the resident's morning medications had been documented as administered by the third shift MA not the first shift MA who actually prepared and administered the medications. Interview with the Resident Care Coordinator (RCC) on 07/24/24 at 12:17pm revealed: -The MAs were supposed to document the administration of medications after actually observing a resident take the medication. -The MA who prepared the medication should be	D 366		

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D 366	Continued From page 11 the MA who administered the medication and documented the medication on the eMAR. Interview with the Health and Wellness Director (HWD) on 07/24/24 at 12:35pm revealed: -She had expressed concerns to the facility's Clinical Director recently (could not recall date) because there was only 1 MA administering medications in the assisted living (AL) side of the facility with 3 medication carts. -They had just started assigning 2 MAs for the AL side of the facility today. -The MA who prepared the medication was supposed to administer it and document it on the eMAR after observing the resident take the medication. Interview with the Administrator on 07/24/24 at 12:55pm revealed: -The MAs should follow the seven rights of medication administration and no pre-pouring was allowed. -The MA who prepared the medication should administer the medication and document the administration of the medication immediately after observing that resident take the medication.	D 366		
D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications	D 377		

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were stored in a safe and secure manner in accordance with the facility's policies and procedures for 3 of 3 residents sampled (#6, #7, and #8) who self-administered medications.

The findings are:

Review of the facility's Medication Storage Policies and Procedures dated 03/2006 revealed:
-Residents who self-administer their own medications may store and secure their non-controlled medications in their apartments by locking the apartment door each time upon departure.
-Residents who self-administer their own medications should store their controlled medications in a locked drawer or cabinet so they are not accessible to others.

1. Review of Resident #6's current FL-2 dated 01/08/24 revealed:
-Diagnoses included hypertension, gastroesophageal reflux disease, hyperlipidemia, and hypothyroidism.
-He was semi-ambulatory and there was no information on orientation.
-There was no admission date.
-He had an order to self-administer medications.

Observation of Resident #6's room on the assisted living (AL) side of the facility on 07/24/24 at 8:24am revealed:
-His door was unlocked and he was not in his room.
-There were 14 medication cards on a table.
-The table contained the following medications: Simvastatin 40mg (used to treat high cholesterol), Finasteride 5mg (used to treat benign prostatic hyperplasia), Farxiga 10mg (used to treat type 2 diabetes), Melatonin 5mg (used to treat

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insomnia), Furosemide 20mg (used to treat fluid retention), Tamsulosin 0.4mg (used to treat men with symptoms of an enlarged prostate gland), Ferrous Sulfate 325mg (used for treating low levels of iron), Vitamin B-12 500mcg (a supplement), Glimepiride 2mg (used to treat high blood sugar levels caused by type 2 diabetes), Levothyroxine 125mcg (used to treat hypothyroidism), Donepezil 5mg (used to treat dementia), Trazodone 50mg (used to treat depression and anxiety), Omeprazole 40mg (used to treat acid reflux), Vitamin D2 50,000u (used to treat vitamin D deficiency).

Interview with Resident #6 on 07/24/24 at 9:50am revealed:
-He stored his medications under his sink in a cardboard box.
-He did not lock his door when he left his room.
-He only locked his door at night when he went to sleep.

Refer to interview with a medication aide (MA) on 07/24/24 at 8:45am.

Refer to interview with the Resident Care Coordinator (RCC) on 07/24/24 at 9:15am.

Refer to interview with the Health and Wellness Director (HWD) on 07/24/24 at 2:20pm.

Refer to the interview with the Administrator on 07/24/24 at 2:40pm.

2. Review of Resident #7's current FL-2 dated 04/05/24 revealed:
-Diagnoses included type 2 diabetes, hypertension, gastroesophageal reflux disease, and hyperlipidemia.
-She was ambulatory and there was no

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	HAL092032	A. BUILDING: _____ B. WING _____	R 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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 377	Continued From page 14	D 377		

information on orientation.
-The admission date was 06/02/23.
-She had an order to self-administer medications.

Observation of Resident #7's room on the assisted living (AL) side of the facility on 07/24/24 at 8:15am revealed:
-Her door was unlocked and she was not in her room.
-She did not have a lock on her bedroom door.

Interview with Resident #7 on 07/24/24 at 10:10am revealed:
-She stored her medications in an unlocked bathroom cabinet.
-She was not able to lock her door when leaving her room because she did not have a lock on her door.

Refer to interview with a medication aide (MA) on 07/24/24 at 8:45am.

Refer to interview with the Resident Care Coordinator (RCC) on 07/24/24 at 9:15am.

Refer to interview with the Health and Wellness Director (HWD) on 07/24/24 at 2:20pm.

Refer to the interview with the Administrator on 07/24/24 at 2:40pm.

3. Review of Resident #8's current FL-2 dated 01/29/24 revealed:
-Diagnoses included chronic obstructive pulmonary disease, asbestos exposure, chronic respiratory failure and hypertension.
-He was ambulatory and there was no information on orientation.
-The admission date was 01/25/24.
-He had an order to self-administer medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 377	Continued From page 15 Observation of Resident #8's room on the assisted living (AL) side of the facility on 07/24/24 at 8:10am revealed: -His door was unlocked. -There were medications on the dresser. -The dresser contained the following medications: Maxitrol ointment (used to treat conditions involving swelling eyes), Betamethasone Dipropionate (used to help relieve redness, itching, and swelling), and Fluticasone nasal spray (used to treat sneezing, itchy or runny nose). Interview with Resident #8 on 07/24/24 at 9:40am revealed: -He did not lock his door when he left his bedroom. -He kept most of his medications in his lockbox. Refer to interview with a medication aide (MA) on 07/24/24 at 8:45am. Refer to interview with the Resident Care Coordinator (RCC) on 07/24/24 at 9:15am. Refer to interview with the Health and Wellness Director (HWD) on 07/24/24 at 2:20pm. Refer to the interview with the Administrator on 07/24/24 at 2:40pm. _____ Interview with a medication aide (MA) on 07/24/24 at 8:45am revealed: -The residents that administered their own medications were supposed to keep their doors closed and locked when they left their rooms. -Residents that self-administered medications had keys to their rooms in order to lock their door to secure their medications.	D 377		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 377	Continued From page 16 -Staff members did not check to ensure residents that self-administered medications locked their doors when they left their rooms. -There was a concern that a resident would go into someone's room and take medications that were not prescribed to them. Interview with the Resident Care Coordinator (RCC) on 07/24/24 at 9:15am revealed: -The Health and Wellness Director (HWD) was responsible for ensuring monthly that residents who self-administered medications were capable of doing so. -All residents that administered their own medications were supposed to have a lockbox and lock their doors when not in their room. -Residents who stored their medications in their room caused safety concerns if they did not lock up their medications properly. -There was a concern that another resident could go into a resident's bedroom and have access to medications that were not prescribed to them. Interview with the HWD on 07/24/24 at 2:20pm revealed: -Residents who administered their own medications had to lock their doors when they left their rooms. -Medications must be secured for safety purposes because another resident or someone could have taken unsecured medications. -Residents that administered their own medications should have been reminded more frequently the importance of locking their doors. -She was not aware that Resident #7 did not have a lock on her door. -She and the MAs were responsible to ensure residents that administered their own medications secured their medications properly.	D 377		

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D 377	Continued From page 17 Interview with the Administrator on 07/24/24 at 2:40pm revealed: -The facility's policy for storage of self-administered medications was medications should be locked in the resident's room, and controlled substances should be double locked in a lock box and a locked door. -She expected all residents who administered their own medications to lock their doors when they left their rooms. -She was not aware that Resident #7 did not have a lock on her door. -The RCC was responsible for ensuring residents that administered their own medications were capable of doing so. -All staff members were responsible for making sure medications were secure. -She did not know why the residents that administered their own medications were not securing their medications properly.	D 377		