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	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brook Stone Living Center	8990 Highway 17 South Pollocksville, NC 28573

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49159 Based on observation and staff interviews, the facility failed to maintain shared resident bathrooms in good repair (Rooms #112 and #114) and maintain clean resident bathrooms (Rooms #308 and #310) for 2 of 12 shared resident bathrooms reviewed for environment. The findings included: a. Observation of the shared resident bathroom for Rooms #112 and #114 on 4/29/24 9:08 AM revealed the wall around the plumbing behind the toilet had missing drywall. A black, brown, and green substance was observed to surround the missing drywall around the plumbing to the toilet. The baseboard behind the toilet was observed to be pulled back from the wall and exposed missing drywall. On 5/01/24 at 1:03 PM an observation of the shared resident bathroom for Rooms #112 and #114 revealed the wall around the plumbing behind the toilet had missing drywall. A black, brown, and green substance was observed to surround the missing drywall around the plumbing to the toilet. The baseboard behind the toilet was observed to be pulled back from the wall and exposed missing drywall. b. Observation of the shared resident bathroom for Rooms #308 and #310 on 4/28/24 at 12:03 PM revealed the toilet to have a brown, black substance around the caulking of the base of the toilet. On 5/01/24 at 1:09 PM an observation of shared resident bathroom for Rooms #308 and #310 revealed the toilet to have a brown, black substance around the caulking of the base of the toilet. The substance was able to be removed with light friction. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continuous observation and interview were conducted on 5/1/24 from 1:18pm through 1:21 PM with the Maintenance Manager, Housekeeping Manager, and Administrator for shared resident bathrooms for Rooms #112 and #114 and Rooms #308 and #310. The Maintenance Manager stated he was unaware of missing drywall and a substance around the plumbing in shared bathroom for resident Rooms #112 and #114. He further revealed he was not aware the baseboard was not affixed to the wall. He stated it appeared as though there was moisture that was causing what looked like it could be mold. The Maintenance Manager stated he should have been notified about these issues. He indicated he conducted monthly maintenance rounds of the facility. Regarding shared bathroom for resident Rooms #308 and #310, the Housekeeping Manager stated the substance around the caulking of the base of the toilet could have been due to a buildup of excess water when the bathroom floors were mopped. She further stated that housekeeping staff should scrape around caulked areas to remove the built-up substance. The Maintenance Manager added that the toilet in shared resident bathroom for resident Rooms #308 and #310 needed re-caulking. In an interview with the Administrator on 5/01/24 at 1:29 PM she revealed staff should notify the Maintenance Manager of any maintenance concerns regarding shared bathroom for resident Rooms #308 and #310. She further revealed housekeeping staff were to ensure resident bathrooms remain clean.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502 Based on observation, record review, resident and staff interviews, the facility failed to accurately code the current tobacco use status on a Minimum Data Set (MDS) Assessment for 1 of 1 resident (Resident #50) reviewed for smoking. The findings included: Resident #50 was admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was cognitively intact and coded No for current tobacco use. On 4/28/24 at 3:05 pm Resident #50 was observed smoking a cigarette unsupervised in the designated smoking area. An interview with Resident #50 on 4/30/24 at 12:01 pm revealed he kept on his person his smoking supplies which included his cigarettes and a lighter. The resident further indicated he had been a smoker for over [AGE] years. During an interview with the MDS Coordinator on 4/30/24 at 3:12 pm she stated Resident #50 was a smoker and smoking had not been coded correctly on his MDS assessment. An interview with the MDS Corporate Consultant on 4/30/24 at 3:25 pm revealed the procedure was for the MDS Coordinator to review physician's orders, receive information from the morning meetings and interview residents to make sure the information entered on the MDS was accurate. The Director of Nursing was interviewed on 4/30/24 at 3:05 pm. She indicated the floor nurses assessed residents for smoking when they were admitted . The MDS assessment should have been correctly coded at the time of admission. During an interview with the Administrator on 5/1/24 at 9:24 am she indicated the MDS should have reflected Resident #50's smoking status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502 Based on observation, record review, resident and staff interviews, the facility failed to develop a comprehensive person-centered care plan for a resident that smoked for 1 of 1 resident (Resident #50) reviewed for supervision to prevent accidents. The findings included: Resident #50 was admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was cognitively intact and coded for no tobacco use. Review of Resident #50's comprehensive care plan dated 6/20/23 and last updated 9/20/23 revealed he was not care planned for smoking. Nursing progress notes dated 8/15/23, 9/21/23, and 9/26/23 indicated Resident #50 was a current smoker. Observation of Resident #50 on 4/28/24 at 3:05 pm in the smoking area of the facility, revealed he was smoking unsupervised. Interview with Resident #50 on 4/30/24 at 12:01 pm revealed he kept his smoking supplies to include his cigarettes and a lighter on his person. The resident further indicated he had been a smoker for over [AGE] years and smoked half a pack a day. During an interview with the MDS Coordinator on 4/30/24 at 3:12 pm she stated she completed the care plans and all residents who were smokers should have had a care plan to include interventions. Resident #50 should have had a care plan to include smoking interventions. An interview with the MDS Corporate Consultant on 4/30/24 at 3:25 pm stated a care plan should have been completed to reflect a resident who was a current smoker. Resident #50 should have had a care plan for smoking. An interview with the Administrator on 5/1/24 at 9:24 am revealed nursing should have reassessed Resident #50 as soon as they realized he was smoking, and a care plan completed to reflect his smoking status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502 Based on observation, record review, resident and staff interviews, the facility failed to assess a resident's ability to smoke independently and retain smoking materials for 1 of 1 resident reviewed for smoking. (Resident #50) The findings included: Resident #50 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia, with other behavioral disturbance. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was cognitively intact and coded for no tobacco use. Review of Resident #50's comprehensive care plan dated 6/20/23 and last updated 9/20/23 revealed he was not care planned for smoking. A review of the medical record revealed no smoking assessment completed for Resident #50. A nursing progress note written by the Administrator dated 8/15/23 indicated Resident #50 was alert and oriented to person, place, and time. Resident #50 was able self-propel from one unit to another and was a current smoker. Review of nursing progress note written by the Assistant Director of Nursing (ADON) dated 9/21/23 indicated Resident #50 was alert and oriented and continued to smoke. The nursing progress note written by the Assistant Director of Nursing (ADON) dated 9/26/23 indicated Resident #50 was alert and oriented. He was a current smoker who smoked in the designated smoking area independently. Observation of Resident #50 on 4/28/24 at 3:05 pm in the smoking area of the facility, revealed he was smoking unsupervised. Interview with Resident #50 on 4/30/24 at 12:01 pm revealed he kept his smoking supplies to include his cigarettes and a lighter on his person. The resident further indicated he had been a smoker for over [AGE] years and smoked half a pack of cigarettes a day. The Director of Nursing (DON) was interviewed on 4/30/24 at 3:05 pm. She indicated the floor nurse would assess residents for smoking upon admission. The Assistant Director of Nursing (ADON) was interviewed on 5/1/24 at 12:28 pm. She revealed Resident #50 was a current smoker. She further stated that she had encouraged Resident #50 to inform the staff when he was going to smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 5/1/24 at 9:24 am revealed she was aware Resident #50 was a smoker. She further revealed the floor nurse was responsible for completing smoking assessments upon admission to the facility. She indicated she did not know Resident #50 was smoking upon admission and that could have been a reason his smoking assessment was missed. Nursing should have reassessed Resident #50 as soon as they realized he was smoking. Resident #50 did not have a smoking assessment and one should have been completed as he was a smoking resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50415 Based on observations, record review, staff and physician interviews, the facility failed to administer oxygen (O2) in accordance with the physician's order and they failed to have cautionary signage for O2 use for 1 of 1 resident (Resident #35) reviewed for respiratory care. The findings included: 1a. Resident #35 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure. A review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #35 was severely cognitively impaired. She had received oxygen therapy and tracheostomy (trach) care during the MDS assessment period. Resident #35's care plan dated revealed 4/26/24 revealed the resident had a tracheostomy related to impaired breathing mechanics. The goals revealed the resident would have clear and equal breath sounds in both lungs and that the resident would be monitored for breath sounds each shift. The intervention stated the oxygen would be delivered by a trach mask at 6 liters per minute (lpm). A review of Resident #35's physician order dated 5/15/23 revealed an order for oxygen delivered via trach collar at 6 lpm indefinitely. An observation of Resident #35 was conducted on 4/28/24 at 12:17 PM. Resident #35 was lying in bed wearing a trach collar with oxygen being delivered at 4.5 lpm. The resident did not have any signs or symptoms of distress. Another observation of Resident # 35 conducted on 4/29/24 at 8:44 AM revealed Resident #35 was lying in bed wearing a trach cannula with oxygen being delivered at 4.5 lpm. The resident did not have any signs or symptoms of distress. An additional observation of Resident #35 conducted on 4/30/24 at 8:32 AM revealed Resident #35 was lying in bed wearing a trach cannula with oxygen being delivered at 4.5 lpm. The resident did not have any signs or symptoms of distress. An interview conducted with Nurse #3 on 4/30/24 at 9:48 AM. She stated Resident #35 had an order for 6 lpm continuous oxygen. Nurse #3 stated she had not assessed the resident yet that morning and was not aware her oxygen was set at 4.5 lpm. An interview was conducted with the Director of Nursing (DON) on 5/1/24 at 09:54 AM. She stated staff were to follow the doctor's orders for oxygen administration. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview of Nurse #1 conducted on 5/1/24 at 1:05 PM revealed the oxygen orders for each resident were found in the electronic chart. Nurse #1 stated she checked the oxygen concentrator for Resident #35 every shift to make sure it was on the correct setting. She stated she did not check the chart orders every shift and further stated the O2 orders for Resident #35 were supposed to be set at 6 lpm. She stated she did not note the oxygen had been incorrect on the shifts she worked 4/28/24 and 4/29/24. Nurse #2 could not be reached by telephone for an interview during survey. A telephone interview was conducted with the physician on 5/1/24 at 1:48 PM. He stated staff were to follow his orders as written. The Administrator on 5/1/24 at 1:46 PM. She revealed staff should be checking the residents' orders each shift. She further revealed staff should follow the doctor's orders. 1b. An observation of Resident #35 was conducted on 4/28/24 at 12:17 PM. There was no cautionary or safety signage for the use of oxygen observed in Resident #35's room, outside her room, or anywhere in her environment. Observation of Resident #35 conducted on 4/29/24 at 8:44 AM revealed there was no cautionary signage in Resident #35's room, outside her room, or anywhere in her environment. An additional observation of Resident #35 conducted on 4/30/24 at 8:32 AM revealed there was no cautionary signage in Resident #35's room, outside her room, or anywhere in her environment. An interview with Nurse #3 was conducted on 4/30/24 at 9:48 AM. Nurse #3 stated there should have been oxygen in use signage on Resident #35's door. An interview and observation conducted with the Director of Nursing (DON) and Administrator on 5/1/24 at 9:54 AM revealed oxygen in use signage should be on Resident #35's door. The Administrator stated the oxygen signage had been placed on the incorrect resident's door.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49159 Based on observation, record review, and staff interview the facility failed to remove expired medications from the refrigerator for 2 of 2 med rooms. Findings included: 1a. An observation on 05/01/24 at 1:31 PM in the presence of the Director of Nursing (DON) revealed the medication room [ROOM NUMBER] (100 hall) refrigerator had 5 expired antibiotics. There were 2 expired Intravenous (IV) antibiotic infusion doses for a resident who was no longer in the facility with the expiration date of 4/8/24. An additional 3 expired IV antibiotic infusion doses were found for another resident with an expiration date of 4/19/24. 1b. Per the manufacturer's recommendation for Purified Protein Derivative (PPD) storage, PPD vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. An observation on 05/01/24 at 1:52 PM in the presence of the DON revealed the medication room [ROOM NUMBER] (300 hall) refrigerator had 2 multidose vials of Tuberculin Purified Protein Derivative (PPD for Tuberculosis skin test) found opened and not dated. An interview conducted with the DON on 05/01/24 at 1:57 PM revealed the facility pharmacy technician comes every month to inspect/review medications stored at the facility. She stated they have a new pharmacy technician. The DON stated the nursing staff are supposed to date any medication once opened and remove any expired medications. On 05/01/24 at 3:02 PM an interview with the administrator was conducted. She stated as soon as medication is no longer used or needed it must be removed from facility storage. She added that all opened medications must be dated once opened before it is stored.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50415 Based on observations, record review and staff interviews, the facility failed to ensure medical records were complete and accurate for 1 of 1 resident reviewed for respiratory services (Resident #35). The findings included: Resident #35 was admitted to the facility on [DATE] with a diagnosis of chronic respiratory failure. A review of Resident #35's Minimum Data Set (MDS) dated [DATE] revealed she was severely cognitively impaired. She had received oxygen therapy and tracheostomy care during the MDS assessment period. A review of the physician's order dated 5/15/23 revealed Resident #35 was to receive oxygen by tracheostomy (trach) collar at 6 liters per minute (lpm) indefinitely. An observation of Resident #35 was conducted on 4/28/24 at 12:17 PM. Resident #35 was lying in bed wearing a trach collar with oxygen being delivered at 4.5 lpm. The resident did not have any signs or symptoms of distress. Another observation of Resident # 35 conducted on 4/29/24 at 8:44 AM revealed Resident #35 was lying in bed wearing a trach cannula with oxygen being delivered at 4.5 lpm. The resident did not have any signs or symptoms of distress. Review of Resident #35's Medication Administration Record (MAR) for April 2024 revealed Nurse #1 (AM shift) and Nurse #2 (PM shift) had documented with electronic initials that Resident #35 was receiving oxygen at 6 lpm by trach collar on 4/28/24. Further Review of the April 2024 MAR revealed Nurse #1 and Nurse #2 had again documented with electronic initials that Resident #35 was receiving oxygen at 6 lpm by trach collar on 4/29/24. A telephone interview of Nurse #1 conducted on 5/1/24 at 1:05 PM revealed the oxygen orders for each resident were found in the electronic chart. Nurse #1 stated she checked the oxygen concentrator for Resident #35 every shift to make sure it was on the correct setting. She stated she did not check the chart orders every shift and further stated the oxygen orders for Resident #35 were supposed to be set at 6 lpm. She stated she did not note the oxygen had been incorrect on the shifts she worked 4/28/24 and 4/29/24. Nurse #2 could not be reached by telephone for an interview during survey. The Director of Nursing (DON) interview was conducted on 5/1/24 at 09:54 AM. She stated staff should document correct oxygen assessments. The Administrator was interviewed on 5/1/24 at 1:46 PM. She stated staff should document correct oxygen assessments.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49159 Based on observation, record review and resident and staff interview the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 10/6/21 recertification survey and the 1/20/23 recertification and complaint investigation survey. This was for 3 recited deficiencies on the current recertification and complaint survey of 5/1/24 in the areas of accuracy of assessment (F641), development/implement comprehensive care plan (F656), and label/store drugs and biologicals (F761). The continued failure during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F 641 Based on observation, record review, resident and staff interviews, the facility failed to accurately code the current tobacco use status on a Minimum Data Set (MDS) Assessment for 1 of 1 resident (Resident #50) reviewed for smoking. During the 10/6/21 recertification survey the facility failed to accurately code the Minimum Data Set (MDS) for weight loss, anticoagulants, and indwelling catheter. During the 1/20/23 recertification and complaint survey the facility failed to accurately complete the Minimum Data Set (MDS) for discharge and anticoagulant (blood thinning medication). F 656 Based on observation, record review, resident and staff interviews, the facility failed to develop a comprehensive person-centered care plan for a resident that smoked for 1 of 1 resident (Resident #50) reviewed for supervision to prevent accidents. During the 1/20/23 recertification and complaint survey the facility failed to develop and implement a comprehensive individualized person-centered care plan. F 761 Based on observation, record review, and staff interview the facility failed to remove expired medications from the refrigerator for 2 of 2 med rooms. During the 10/6/21 recertification survey the facility failed to discard expired medications in medication carts, and narcotics in the narcotic lock box contained no expiration date in a medication cart. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 05/01/24 at 4:10 PM with the Administrator. She stated the quality assurance (QA) committee met both monthly and quarterly. The committee members included the Social Worker, Activity Director, Therapy Manager, Admission Coordinator, Business Office Manager, Dietary Manager, Maintenance Manager, Director of Nursing, Assistant Director of Nursing, Administrator, and Medical Records Manager. She added that currently the QA committee was attempting to identify issues with nursing documentation, as well as laboratory results. The Administrator stated the last MDS nurse had to leave the position and the facility went for a period without an MDS coordinator, so she stepped in to cover this role. She elaborated that they now have a new MDS Coordinator. Regarding failure to develop/implement care planning, she stated that the MDS coordinator was also responsible for develop/implement care planning. The new MDS/Care Plan Coordinator did not have experience in either area (MDS, care planning), and she was currently being trained on the job.