

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2025
NAME OF PROVIDER OR SUPPLIER  Brook Stone Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 [ROOM NUMBER]) on 1 of 2 halls observed for a clean, safe, comfortable, and homelike environment.</p> <p>The findings included:</p> <p>An observation of room [ROOM NUMBER] 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 [ROOM NUMBER].</p> <p>A second observation of room [ROOM NUMBER] was made on 6/2/25 at 2:30 pm and the PTAC unit remained dislodged from the wall on the right side.</p> <p>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 [ROOM NUMBER] 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 [ROOM NUMBER]. The Maintenance Director further stated the outside shouldn't be seen while inside the room unless you were looking out of a window.</p> <p>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 [ROOM NUMBER]. 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.</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2025
NAME OF PROVIDER OR SUPPLIER  Brook Stone Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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).</p> <p>The findings included:</p> <p>Resident #32 was admitted to the facility on [DATE] with diagnoses including mood disorder.</p> <p>Resident #32's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was rarely/never understood, and a staff assessment for mood should be conducted but was not.</p> <p>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.</p> <p>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.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2025
NAME OF PROVIDER OR SUPPLIER  Brook Stone Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>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.</p> <p>The findings included:</p> <p>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.</p> <p>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.</p> <p>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 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.</p>