

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL014010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/24/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE LENOIR		STREET ADDRESS, CITY, STATE, ZIP CODE 1145 POWELL ROAD NE LENOIR, NC 28646		
(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 conducted an annual survey on September 23-24, 2015.	D 000		
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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents (#5) related to decreased cognition, verbal and physical aggression and needing a higher level of care. The findings are: Review of Resident #5's current FL2 dated 2/4/15 revealed: -Diagnoses included depression. -Medications included Aricept 10mg at bedtime (used to treat mild to severe dementia in Alzheimer's disease), Cymbalta 60mg daily (treat depression) and Xanax 0.25mg three times a day (anti-anxiety medication). -The recommended level of care was domiciliary. -She was noted to be intermittently disoriented. -She required personal care assistance with bathing. -No diagnoses of dementia, Alzheimer's Disease or memory loss.	D 273		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Karen Green
STATE FORM

TITLE

Executive Director
VQH211

(X8) DATE

10-29-15

*Reviewed and approved
10/29/15
Susan H. [unclear]*

The following is the Plan of Correction for Brookdale Lenoir regarding the Statement of Deficiencies dated 10/15/15. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

Tag 0273, 10A NCAC 13F .0902 (b) Type B Violation

Based on review and physician involvement, Resident #5 was moved to a higher level of care.

Associates will be trained to ensure the residents' provider and the ED/HWD or Designee are notified of changes related to physical decline, decreased cognition, verbal and physical aggression and needs for change in level of care. This training will be presented by the

Jessica M. [unclear]
Approved and
10/29/15

RN and completed by November 8, 2015. Changes in acute physical and behavioral needs will be noted in the resident record and documented on for 72 hours or until resolved (Hot box). Changes in other areas, including level of care needs will be documented ongoing with the plan for care updated as needed. Training agenda and attendance forms will be maintained in the community by the Business Office Coordinator. The HWD will monitor the acute documentation on a daily basis and the ED will follow up weekly with the HWD. The date of completion for this Type B will not exceed November 8, 2015

Tag 0338, 10A NCAC 13F .0900
Resident Rights Type A2 violation

Based on review and physician involvement, Resident #5 was moved to a higher level of care.

Right to freedom from abuse will be discussed at each all associate meeting. Training attendance forms will be maintained in the community. Associate training will be held by the Regional Ombudsman at the community for all associates on or by 10/24/15. A resident's rights meeting for residents and families will be scheduled to educate on Resident Rights. This will be presented by the Executive Director. A sign in sheet will be maintained in the community. Follow up sessions will be help during resident

meetings and family meetings
quarterly or as needed. The
date of completion for this Type
A2 violation will not exceed
10/24/15.

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER
BROOKDALE LENOIR

STREET ADDRESS, CITY, STATE, ZIP CODE
**1145 POWELL ROAD NE
LENOIR, NC 28645**

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TITLE

(X6) DATE

Division of Health Service Regulation

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D 273	<p>Continued From page 1</p> <p>Review of the Resident Register revealed admission to the facility on 11/27/13.</p> <p>Review of a History and Physical Form from a prior facility dated 11/7/13. revealed: -It referenced Resident #5 as having "dementia and some memory impairment." -A diagnosis of dementia was listed under "Past Medical History." -The resident had been alert and oriented x 2, with slow followup. -A diagnosis of Alzheimer's disease had been documented under "Diagnosis and Assessment." -The physician had documented under "Plan", the resident had "dementia which will likely worsen."</p> <p>Review of a physician's report dated 11/7/13 for Resident #5 revealed: -Documentation of a history of "still very significant short term memory loss." -Upon physical examination it was noted the resident had moderately impaired short term memory loss.</p> <p>Review of a physician's report dated 9/5/15 for Resident #5 revealed: -Pain in finger of left hand had been the primary condition addressed during the visit. -Current health issues included memory loss. -No medication changes related to memory loss. -The next office visit had been scheduled for 1/21/16. -There was no documentation the physician had been notified of the resident's on-going behaviors ("collecting" from other residents (personal items and clothing) and from the facility (napkins, silverware, sugar packets and glassware from the dining room), keys to a medication cart and keys to the locked areas in the facility) and hiding them</p>	D 273		

Division of Health Service Regulation

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D 273	<p>Continued From page 2</p> <p>in her closet, purse or under her mattress, going into and out of other resident's rooms without their permission and/or knowledge, refusing and/or resisting personal care (showers), demonstrations of affection toward the male residents (hugging, touching, rubbing, kissing), using of profanity when speaking with her roommate/roommate's family and slapping a male resident across the face).</p> <p>Review of Resident #5's record revealed: -An entry in the Staff Notes, dated 6/1/15 at 2:00pm, documenting "the resident was in the dining room, became very upset and slapped another resident across the face". -The facility had informed the resident's physician, by fax the same day, of the incident describing the behavior and adding, "We just wanted for you to be informed of this behavior." -There was no confirmation from the physician's office the fax had been received. -The facility then notified Resident #5's family member who was upset he had been called. -There were no additional entries noting behaviors for the resident.</p> <p>Interview on 9/23/15 at 9:10am with Resident #5 revealed: -She had lived in this apartment building for 7 months. -She was not a diabetic. -Other residents had been stealing her personal belongings since she moved in. -Her roommate had stolen her clothes, toothpaste, dentures, make-up, snacks, books and pictures and locked them away and she did not have a key to the closet.</p> <p>Observation of Resident #5 during the interview on 9/23/15 at 9:10am revealed she had provided</p>	D 273		

Division of Health Service Regulation

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D 273	<p>Continued From page 3</p> <p>inaccurate information indicating her confusion and disorientation.</p> <p>Interview on 9/23/15 at 9:20am with Resident #5's roommate (Resident #4) revealed:</p> <ul style="list-style-type: none"> -She was alert and oriented. -They had been roommates for over a year. -In the beginning, Resident #5 "stole everything I owned." -She had taken her glasses and the glasses were never found. -She took and/or used everything that wasn't locked up. -Her cabinet in the bathroom was empty because Resident #5 thought everything in the bathroom was hers and it ended up in Resident #5's cabinet. -Resident #5 locked the roommate out of the room and the roommate ended up waiting for staff or other residents to help her get the door open. -She wakes up in the middle of the night, turns on the overhead light and leaves the room and the roommate cannot go back to sleep. <p>Confidential interviews with 8 residents regarding Resident #5 revealed:</p> <ul style="list-style-type: none"> -The resident went into all of their rooms uninvited. -Four residents now locked their doors when out of their rooms during the day and at bedtime, to keep her out. -Two residents had cell phone chargers taken from their rooms that were later found in Resident #5's room. -Two residents had clothing taken which the staff later found in Resident #5's room. -Six residents had seen Resident #5 slap a male resident across the face in the dining room and stated they "stay out of her way." 	D 273		

Division of Health Service Regulation

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D 273	<p>Continued From page 4</p> <ul style="list-style-type: none"> -All residents stated they tried to stay out of her way, they were "careful" around her because they felt she was "unpredictable". -Two residents stated they had heard Resident #5 accused her roommate (Resident #4) of stealing her clothes and when the roommate denied it, Resident #5 called her a "(profane expletives)". -One resident had heard Resident #5 call a family member of Resident #4 a "(profane expletives)" when she removed some of Resident #4's clothing from Resident #5's closet. -They described Resident #5 as "a kleptomaniac", "a pathological liar", "very flirty", "too touchy feely" and "unpredictable." -All had observed Resident #5 take silverware, napkins, packets of sugar and glasses from the dining room in her purse on a regular basis. <p>Interview on 9/23/15 at 11:25am with a family member of Resident #5 revealed:</p> <ul style="list-style-type: none"> -She had been admitted to the facility because she was no longer safe at home alone. -Since admission to the facility, the resident "had become more withdrawn due to her dementia". -"She thinks someone is stealing from her but she is the one who will have other resident's things in her purse". -"She does end up with her roommate's possessions and some of the roommate's things got gone". -"The current roommate understands she has Alzheimers and why she acts and does what she does." <p>Confidential interview with a staff member concerning Resident #5 revealed:</p> <ul style="list-style-type: none"> -"She is the one taking other residents' personal items and hiding them in her room". -"She sleeps in her clothes, coat and with her 	D 273		

Division of Health Service Regulation

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D 273	<p>Continued From page 5</p> <p>pocketbook in the bed so the staff won't know what she had that didn't belong to her".</p> <p>-"She is unique, flirtatious and not orientated to time or place".</p> <p>-"She likes to wear men's underwear and T-shirts and likes to rub, touch, hug and kiss the male residents."</p> <p>-"She had been in a relationship with a male resident who is no longer at the facility. He accused her of stealing his things and she slapped him across the face in the dining room".</p> <p>-"More recently, she has become a routine"collector" of items from the dining room like silverware, napkins, packets of sugar, which she hides in her purse and in her room.</p> <p>-"The other residents have made us (care staff) aware she is going into their rooms and taking things like deodorant, books, make-up, clothes, and cell phone chargers".</p> <p>-"We try to keep an eye on her so she doesn't bother the other residents but she walks a lot and it's impossible to watch her all the time".</p> <p>-"Currently she has been taking off door decorations, like wreaths, and hiding them in her room/closet".</p> <p>-"She's bad to go around the medication carts and stand and look at what's on top or in the drawers when the Medication Aide (MA) opens them."</p> <p>-"Several months ago, a Medication Aide on the 2:00pm to 10:00pm shift left the keys in the medication cart lock and those keys and the master keys from inside the cart, went missing".</p> <p>-"Several staff went to Resident #5's room and "tore it apart" looking for the keys, but could not locate them".</p> <p>-"Early the next morning, the keys were found in her purse".</p> <p>-"Her roommate had fallen in the past so we leave the bathroom light on and the door cracked</p>	D 273		

Division of Health Service Regulation

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D 273	<p>Continued From page 6</p> <p>so she can find her way. Resident #5 has turned off the light and/or completely closed the bathroom door".</p> <p>- "She routinely locked her roommate out of the room and the staff or other residents help her open the door".</p> <p>- This past year the staff member had seen a marked decline in the resident's memory.</p> <p>- She had observed her to be more confused from dinner time to when she went to bed.</p> <p>- Resident #5 did wander but she was not aware of any exit seeking behaviors or of the resident using foul language.</p> <p>- The resident could be resistant to care, especially with showering, but "we're used to it with her."</p> <p>- "This resident's behaviors, and the other resident's and staff concerns about those behaviors, had been shared by the staff with the Resident Care Coordinator (RCC), the Health and Wellness Director (HWD) and the Administrator at daily stand-up meetings (staff and management) and at monthly staff meetings (all staff and management).</p> <p>- The staff is frustrated because the residents are frustrated due to Resident #5's behaviors.</p> <p>- "I feel bad for her. I really don't feel this is the right place for her".</p> <p>- She was not aware if the primary care physician for Resident #5 had been made aware of her behaviors.</p> <p>Confidential interview with a second staff member regarding Resident #5 revealed:</p> <p>- Other residents had made the staff aware Resident #5 had been taking their things.</p> <p>- "She was aware the resident put silverware, napkins, packets of sugar, packets of mustard and glassware in her purse on a regular basis before leaving the dining room".</p>	D 273		

Division of Health Service Regulation

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D 273	<p>Continued From page 7</p> <ul style="list-style-type: none"> - "We check her purse every once in a while and put stuff back or throw it away". - The resident really liked men. She would touch, hug and kiss and rub on them. - "She had a boyfriend (a resident who isn't here anymore) she spent a lot of time with. She said he accused her of stealing his stuff at lunch one day so she slapped him across the face". - "She goes in and out of the other residents' rooms and takes their deodorant, books, clothes and "stuff like that. The small stuff ends up in her purse and clothes and the bigger stuff she hides under her coat". - "She pretty much goes where she wants." - "Sometimes she can be easily redirected and sometimes she can be pretty difficult, like when we need to give her a shower. She can get pretty mean and nasty." - The care staff had been telling the Health and Wellness Director, the Resident Care Coordinator and the Executive Director about her behaviors and its effect on the other resident at monthly staff meetings and daily stand-up meeting but "nothing really had changed". <p>Interview on 9/24/15 at 9:15am with the Health and Wellness Director revealed:</p> <ul style="list-style-type: none"> - She had been in the position for one year. - She interacted daily with the residents. - Resident #5 was physically quite healthy. Her dementia was the biggest issue, but she had not observed much change in the resident over the past year. - Resident #5 took other resident's things but could be easily re-directed. - She was aware Resident #5's roommate had issues with her taking her personal items like lotion. - Resident #5 had been in a personal relationship with a male resident who no longer lived there. 	D 273		

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D 273 Continued From page 8

He had accused her of taking his personal belongings and she slapped him across the face.

- She was aware Resident #5 had locked her roommate out of their room.
- She did not feel behavior was a big issue for Resident #5 at this time.
- She was not aware if the facility staff had been monitoring this resident for behavioral changes related to her dementia.
- She had not notified Resident #5's primary care physician because she was not aware of all that was happening with the resident.

Interview on 9/24/15 at 10:20am with the Executive Director regarding Resident #5 revealed

- Resident #5 "walked a lot, was confused, liked attention from men, misplaced her belongings and had dementia of some sort".
- She was not aware Resident #5 had been going into other residents' rooms and taking their things.
- She was not aware a sign had been posted on the roommate's (Resident #4's) closet door or why the sign was there. (Note: The sign, posted by the roommate's family, was an 8.5" by 11" sheet of white paper with red hand lettering as follows: "Attention: All of (Resident #4's) lotion, powders, deodorant, etc., is in her locked closet. That is the only way we can keep anything for her. Please don't get annoyed. This is the only way to keep her things from disappearing". Signed by a Family member of Resident #4).
- She was not aware the resident had been removing silverware, napkins, sugar packets and glassware from the dining room in her pocketbook on a regular basis.
- She was not aware four cell phone chargers belonging to other residents had been found in the resident's room.

D 273

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D 273	<p>Continued From page 9</p> <ul style="list-style-type: none"> -The incident in the dining room was just.... (she took one of her hands and lightly brushed it with the finger of her other hand). -She was not aware Resident #5 had slapped any resident across the face. -She was not aware the resident had been taking decorations off resident's doors and hiding them in her room/closet. -She was not aware the resident had called Resident #4 a "expletive expletive" and Resident #4's family member a "(expletive expletive)" and this had been overheard by other residents. -She was not aware (several months ago) the resident had taken, and hidden, keys for the medication cart. -She was not aware there were residents in the facility who were "careful" around Resident #5 because she was "unpredictable and might hit them too." -She was not aware if the Primary Care Physician and/or the Psychiatrist for Resident #5 had been notified of these behaviors. <p>Interview on 9/24/15 at 10:40am with the RCC related to Resident #5 revealed:</p> <ul style="list-style-type: none"> -"She is very sweet, really likes the men and I have never seen her be mean." -She was not aware the resident had slapped another resident across the face. -She was not aware the resident had taken keys from the medication cart and hidden them from the staff. -She stated the resident was not orientated to time or place. -"I think she has a diagnosis of dementia." -"She required assistance with showering and sometimes the staff could get her in the shower and sometimes they couldn't. If she got mad, you had to step away." -She was not aware if the Primary Care Physician 	D 273		

Division of Health Service Regulation

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D 273	<p>Continued From page 10</p> <p>and/or Psychiatrist had been notified of the resident's behaviors.</p> <p>Telephone interview on 9/24/15 at 2:20pm with Resident #5's Primary Care Physician revealed: -He had not received communication from the facility informing him of behaviors.</p> <p>_____</p> <p>A Plan of Protection was provided by the facility on 9/24/15 as follows: -A physician's appointment would be scheduled to evaluate the residents needs. -They would ensure residents are seen as needed for health care concerns.</p> <p>CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED, NOVEMBER 8, 2015.</p>	D 273		
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to assure 1 resident (Resident #4) was free from mental abuse by 1 resident (Resident #5) who took personal items and exhibited verbal and physical aggression.</p> <p>The findings are:</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL014010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/24/2015
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NAME OF PROVIDER OR SUPPLIER BROOKDALE LENOIR	STREET ADDRESS, CITY, STATE, ZIP CODE 1145 POWELL ROAD NE LENOIR, NC 28645
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D 338	<p>Continued From page 11</p> <p>A. Review of Resident #4's current FL2 dated 3/23/15 revealed: -Diagnoses included L2 compression fracture, depression and falls. -She was oriented and had no inappropriate behaviors. -She was semi-ambulatory with a wheelchair. -She was receiving Hospice services.</p> <p>Review of the Resident Register revealed admission to the facility on 5/1/01.</p> <p>Interview on 9/23/15 at 9:20am with Resident #4 revealed: -She and Resident #5 had been roommates for over a year. -In the beginning, Resident #5 "stole everything I owned." -"She went through my drawers and closet, took my clothes and hid them under her mattress." -"One time she took my purse and the staff found it in another resident's room." -"She takes and/or uses everything I don't lock up. I have to put things like my hair pick in my walker bag so she can't get them." -"I can't leave my dentures in the bathroom because she thinks they are hers." -"She tried to use my toothpaste and tooth brush, and did once, until I had to lock them up." -"I can't keep anything in my cabinet in the bathroom because she says it's hers, takes it and puts it in her cabinet." -"I never have any towels/washcloths because she wads them up and throws them in the shower or on the bathroom floor." -"I have congestive heart failure and get short of breath. She locks me out of our room. I have a key but it's hard to hold onto my walker or sit in my wheelchair and try to open the door. I end up</p>	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 12</p> <p>waiting for staff or other residents to open my door."</p> <p>"I love marshmallows, candy and snack cakes but I had to lock those up too because she takes them and I wouldn't have any."</p> <p>"She got into my dresser draw where I had a plastic bag of old family pictures and she threw them away. She said she was cleaning the room. I was able to find some but some are gone."</p> <p>"She wakes up in the middle of the night, turns on the overhead light and leaves the room and I can't go back to sleep."</p> <p>"One night, it was dark and I felt her rubbing her hands all over me. I asked her what she was doing and she said she was checking to make sure I was alright. She scared me half to death."</p> <p>"She will just sit and stare at me. I am afraid of her. I am afraid she will hit me."</p> <p>"My daughter and I asked for her to be moved or for me to get another room. The Administrator said I had to wait for a room to open up. That was over a year ago."</p> <p>"I used to love it here, but not since she (Resident #5) was put in with me. I hate it."</p> <p>Confidential interviews with 8 residents regarding Resident #5 revealed:</p> <ul style="list-style-type: none"> -The resident went into all of their rooms uninvited. -Four residents now locked their doors when out of their rooms during the day and at bedtime, to keep her out. -Two residents had cell phone chargers taken from their rooms that were later found in Resident #5's room. -Two residents had clothing taken which the staff later found in Resident #5's room. -Six residents had seen Resident #5 slap a male resident across the face in the dining room and stated they "stay out of her way." 	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 13</p> <ul style="list-style-type: none"> -All residents stated they tried to stay out of her way, they were "careful" around her because they felt she was "unpredictable". -Two residents stated they had heard Resident #5 accused her roommate (Resident #4) of stealing her clothes and when the roommate denied it, Resident #5 called her two "profane expletive". -One resident had heard Resident #5 call Resident #4's family member two "profane expletives" when the family member found Resident #4's new clothes in Resident #5's closet and removed them. -They described Resident #5 as "a kleptomaniac", "a pathological liar", "very flirty", "too touchy feely" and "unpredictable." -All had observed Resident #5 take silverware, napkins, packets of sugar and glasses from the dining room in her purse on a regular basis. <p>Confidential interviews with 6 residents revealed:</p> <ul style="list-style-type: none"> -Two residents stated they had heard Resident #5 accuse her roommate(Resident #4) of stealing her clothes and when the roommate denied it, Resident #5 called her "profane expletives". -One resident had heard Resident #5 call Resident #4's family member "profane expletives" when the family member found Resident #4's new clothes in Resident #5's closet and removed them. -They were all aware Resident #5 locked Resident #4 out of the room. <p>Confidential interview with a staff member concerning Resident #4 revealed:</p> <ul style="list-style-type: none"> -She had fallen in the past so the staff left the bathroom light on and the door cracked so she can find her way. Resident #5 had turned off the light and/or completely closed the bathroom door. -She was routinely locked out of the room by her roommate (Resident #5). 	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 14</p> <p>Interview on 9/24/15 at 9:15am with the Health and Wellness Director revealed: -She had been in the position for one year. -She interacted daily with the residents. -She was aware Resident #4 had issues with her roommate (Resident #5) taking her personal items like lotion. -She was aware Resident #4 had been locked out of their room by Resident #5. -She did not feel it (Resident #5's behavior) was a big issue.</p> <p>Interview on 9/24/15 at 10:20am with the Executive Director regarding Resident #4 revealed: -She was aware Resident #4 and her family had waiting for a room change or a roommate change for over a year. -She was not aware there was a sign posted on her closet door or why the sign was there. -She stated she was not aware the resident and her family member had been called "profane expletives" a family by the roommate (Resident #5) and this had been witnessed by other residents. - She was not aware the resident and her family member was afraid of Resident #5.</p> <p>Interview on 9/24/15 at 1:00pm with Resident #4's family member revealed: -Resident #5 would be sweet one minute and nasty the next. -She had heard Resident #5 swear at Resident #4 calling her "profane expletives". -Resident #5 had also called Resident #4's family member "profane expletives" when the family member pointed out that she had Resident #4's clothes. -Resident #4 became short of breathe when</p>	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 15</p> <p>these confrontations occurred.</p> <ul style="list-style-type: none"> -At one point, Resident #4 had been receiving care from an outside agency. The outside agency representative called and urged the family to get the resident moved. The roommate situation was effecting the residents' health. -The family and the resident had requested a room change or a roommate change for over a year. -The Administrator and the RCC had told them it would happen as soon as a room became available. -Resident #4's lifestyle had changed completely since Resident #5 became her roommate. -She is afraid for her loved ones safety. -She eventually had to put a sign on Resident #4's closet door explaining to the staff all lotion, powders, deodorant etc. were locked away because that was the only way to keep her things from disappearing. -Resident #4 used to tell people she loved it there, but now she says she hates it and complains more about everything. -She stated it was not fair for Resident #4 to have to "live in torment". <hr/> <p>A Plan of Protection was provided by the facility on 9/23/15 as follows:</p> <ul style="list-style-type: none"> -Resident #4 would be moved to another room. -Resident #5's actions will be monitored. -Alternative placement would be found for Resident #5 as indicated by the physician. -The Associates will be retrained on resident rights. -The Administrator will speak with the residents to encourage them to report any concerns. <p>CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER</p>	D 338		
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Division of Health Service Regulation

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D 338	Continued From page 16 24, 2015.	D 338		
D914	<p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on observations, records reviews and interviews, the facility failed to assure all residents were free from verbal and physical abuse and neglect related to residents' rights and health care.</p> <p>The findings are:</p> <p>1. Based on observations, interviews and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents (Resident #5) related to decreased cognition, verbal and physical aggression and needing a higher level of care. [Refer to Tag 0273, 10A NCAC 13F .0902(b) (Type B Violation)].</p> <p>2. Based on observations, interviews and record reviews, the facility failed to assure 1 resident (Resident #4) was free from mental abuse by 1 resident (Resident #5) who took personal items and exhibited verbal and physical aggression. [Refer to Tag 0338, 10A NCAC 13F .0909 Residents' Rights (Type A2 Violation)].</p>	D914		