

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 R 12/14/2015
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NAME OF PROVIDER OR SUPPLIER
BROOKDALE LENOIR

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

(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 Section and the Caldwell Department of Social Services conducted a follow-up survey on 12/9/15 and 12/10/15.	{D 000}		
{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 Unabated</p> <p>Based on observation, interviews and record review the facility failed to protect 1 resident (Resident #7) from mental and verbal abuse from another resident (Resident #5).</p> <p>The findings are:</p> <p>A. Review of Resident #7's current FL2 dated 09/25/15 revealed: -Diagnoses included acute chronic renal failure, hyperkalemia, dehydration, diabetes type 2. -She was oriented and had no inappropriate behaviors. -She was semi-ambulatory with a wheelchair.</p> <p>Review of the Resident Register for Resident #7 revealed she was admitted to the facility on 02/27/12.</p> <p>Interview on 12/09/15 at 10:30am with Resident #7 revealed: -She and Resident #5 had been roommates from 11/16/15 through 12/04/15 when Resident #5 was</p>	{D 338}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Karen Proeniz

ED

1-12-16

STATE FORM

6699

VQH212

If continuation sheet 1 of 13

Reviewed and accepted. rm 01/15/16

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{D 338}	<p>Continued From page 1</p> <p>discharged to the hospital.</p> <p>-Resident #5 would ask her to call for help or get her something or talk at night.</p> <p>-When Resident #7 explained to Resident #5 she could no longer help her and she could call staff, Resident #5 would wake her up at night after that to tell her she was "mean, evil, liar and hateful."</p> <p>-Staff would tell Resident #5 she needed to call for assistance instead of having Resident #7 call them for her.</p> <p>-On 12/04/15 about 3:00am Resident #5 woke Resident #7 calling her names and then asking her "are you ready for that razor now."</p> <p>-"I asked her what she meant. She told me she was going to cut my throat with a razor. She scared me so bad I was literally shaking. It took me hours to calm down."</p> <p>-Resident #5 began again telling Resident #7 she was "mean and evil and a liar" and she "would get her".</p> <p>-Resident #7 was afraid to go back to sleep as Resident #5 remained in her own bed.</p> <p>-On 12/04/15 at 6:00am Resident #7 told Staff A Personal Care Assistant (PCA) the threats Resident #5 had made to her when she came in their room.</p> <p>-Staff A assisted Resident #5 to her bed.</p> <p>A follow-up interview on 12/10/15 at 10:20am with Resident #7 revealed:</p> <p>-Resident stated she wanted to help Resident #5 but a family member had told her not to get things for Resident #5 but to encourage her to call staff when she needed something.</p> <p>-Staff also told Resident #7 to have Resident #5 call staff if she needed something, multiple times.</p> <p>-Resident #7 shared she had brought her own hand towels from home and Resident #5 would use them to wipe herself and then throw them in the shower after having a bowel movement.</p>	{D 338}		

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{D 338}	<p>Continued From page 2</p> <ul style="list-style-type: none"> -Resident #5 and her family had an argument in the room in front of her about issues discussed in a meeting with the facility about Resident #5's behavior, including Resident #5's asking Resident #7 to help her, calling out for her to call staff and Resident #5's talking all night. -Resident #5's (family member)"left she was mad at me because she thought I was complaining about her. She didn't speak to me for two hours after her (family member) left." -When staff entered the room on 12/04/15 at 6:00am to assist Resident #5 and Resident #7 for the morning, Resident #7 reports telling Staff A, PCA, Resident #5 had threatened to cut her throat with a razor. -She was afraid to call staff when Resident #5 made threat and had not told anyone until Staff A entered their room and was waiting on Resident #5 while she was in the bathroom. -Staff A removed the disposable razors from the bathroom and searched the room. -Staff A assisted Resident #5 to her bed after she finished in the bathroom. -Resident #7 left the room and went to breakfast. -Resident #7 denied being asked to leave her room and could not recall Resident #5 being asked to leave the room by staff. -About 10:15am Resident #5 slid out of the bed and pulled herself to the bathroom. -Resident #5 again began telling Resident #7 again she was "mean and evil" and she "would get her. She said she would cut my throat." -Resident #5 moved from the bathroom door as if Resident #5 was going out in the hall. -Staff A found Resident #5 in the floor. -Resident #5 "told Staff A she fell but she didn't fall she slid out of the bed" as observed by Resident #7. -Resident #5 was in the room most of that morning until Resident #5 left to go to the hospital 	{D 338}		

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{D 338}	Continued From page 3 and "I went to the dining room for lunch." -She stated at this time she was still afraid of Resident #5. -"I am afraid she will come back. Somehow I'll leave if she comes back in this room." -"The medication aide asked me if I wanted to move after (Resident #5's name) family meeting because she was talking and keeping me up at night but I didn't want to. I have been here 3 years and 9 months." -Resident #5 "wouldn't do for herself unless there was no one in the room." -"She was never really nice. She was having a hard time." Interview on 12/10/15 at 12:30pm with Resident #7's family member revealed: -Family member was familiar with Resident #5. -Resident #7 was losing sleep as Resident #5 was talking to her throughout the night. -Resident #7 would fall asleep during their conversations and the family member knew something was wrong. -Staff would tell family member that Resident #5 was asking Resident #7 to do things for her and call staff from when Resident #5 was admitted. -A family member spoke to the Administrator on 12/02/15 regarding family members concern about roommate. Administrator offered for Resident #7 to move to another room but family member did not want her moved as she had been in that room for years. -Family member spoke with Resident #5 about her adjustment to the facility and "encouraged her that it would get better". -When family member visited with Resident #7 on 12/06/15 the resident asked the family member "Why did family member not come to check on her when Resident #5 threatened her." -She was scared and did not want to stay there if	{D 338}		

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{D 338}	<p>Continued From page 4</p> <p>Resident #5 was coming back. -"I was angry with the facility because they had not called me to let me know (Resident #7's name) had been threatened." - She spoke with the Weekend Manager on duty and was told there were "no witnesses to what was said, it was a he said, she said thing". - "I did not feel it had been checked into well and I really didn't get a good answer." -Weekend Manager had not spoken to Resident #7 about the incident. -"I have been adamant about the facility calling about anything regarding (Resident #7's name). -To family members knowledge staff had not investigated incident and no one had spoken to Resident #7 regarding the incident on 12/04/15.</p> <p>Refer to Interview on 12/11/15 at 10:39am with Staff A, Personal Care Assistant.</p> <p>B. Review of Resident #5's current FL2 dated 11/16/15 revealed: -Diagnosis included dementia, chronic back pain, osteoarthritis, hypertension and hypophosphatemia. -She was oriented and had no inappropriate behavior. -She was semi-ambulatory with a wheelchair.</p> <p>A review of the Resident Register for Resident #5 revealed she was admitted to the facility on 11/16/15 and discharged on 12/04/15.</p> <p>A review of facility incident reports for Resident #5 revealed: -Resident #5 had an unwitnessed fall on 12/04/15 at 6:30am, with no apparent injury/harm. -Additional notes showed Resident #5 fell out of bed and she was not injured. -There was no documentation of Resident #5</p>	{D 338}		

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{D 338}	<p>Continued From page 5</p> <p>making threats to Resident #7.</p> <p>-Resident #5 had another unwitnessed fall on 12/4/15 at 10:30am in her room, with no apparent injury. Additional notes showed "Residents roommate said that (Resident #5) had gotten out of bed and crawled to the bathroom and pulled the call bell. Resident #5 crawled to the door where she was found. Resident #5 states she was chasing children in her room when she fell. She denied being hurt."</p> <p>There was no documentation related to Resident #5 making threats to Resident #7 or residents being separated.</p> <p>A review of the facility call bell system report for Resident #5 in room #37 showed the call bell was used on 12/04/15 at 5:57am, 6:30am, 8:00am, 8:08am (bathroom call light), 8:25am and 10:19am.</p> <p>Observation on 12/09/15 at 10:30 am revealed Resident #5's belongings had been removed from the room.</p> <p>Observation on 12/10/15 at 11:10am of an unopened bag of disposable razors were still on the medication cart and confirmed by Staff D, medication aide (MA) as the razors removed from Resident #5's room.</p> <p>-Staff D stated there were several loose disposable razors in Resident #5's belongings but she threw them away.</p> <p>Interview on 12/10/15 at 10:30am with Staff C (Medication Aide) revealed: -On the day of 12/04/15 she worked on third shift. -Once the threat was discovered and reported the disposable razors were removed.</p>	{D 338}		

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{D 338}	<p>Continued From page 6</p> <p>-There were attempts to separate the residents, but both residents refused to leave the room.</p> <p>There was no documentation of incidents or attempts to separate residents in either resident's chart.</p> <p>Interview on 12/10/15 at 10:45am with Staff B revealed:</p> <p>-She was the Supervisor in Charge (SIC) the morning of 12/04/15.</p> <p>-She came into work at 6:00am.</p> <p>-When she had arrived to work she was informed of Resident #5 threatening to cut her roommate with a razor.</p> <p>-When she had arrived at work the razors had already been removed.</p> <p>-She was unaware if third shift had provided supervision for the resident.</p> <p>-She asked the personal care aides to make frequent checks, at least hourly, on Resident #5.</p> <p>-The personal care aides were in the room more frequently because of the resident's frequent use of the call bell by Resident #5.</p> <p>-Both residents refused to leave their room per SIC.</p> <p>-She did not feel that Resident #5 was a threat to her roommate because of her semi-ambulatory status.</p> <p>-The resident was in bed and the wheel chair was sitting outside of the room.</p> <p>-Their policy is that they do not send residents who fall out to the hospital unless there is an injury involved.</p> <p>-She sent Resident #5 out at around 12:00 noon on 12/04/15 per the Administrators instructions.</p> <p>Interview on 12/10/15 at 3:30 pm with the Administrator revealed:</p> <p>-She was told by the Health and Wellness</p>	{D 338}		

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{D 338}	<p>Continued From page 7</p> <p>Director Resident #5 had 2 falls and had threatened her roommate and had gone to emergency room as the situation had been discussed in the administrative staff's morning meeting.</p> <p>- "The new Registered Nurse (RN) was here and involved in the situation."</p> <p>- The Administrator was out of the facility on 12/04/15 and staff called her early afternoon but she could not remember time.</p> <p>- When the RN called the Administrator she told them to call the family and get Resident #5 medical attention for falls and change in behavior by sending her to the emergency room as the staff had not done so.</p> <p>- Her expectations were her staff should have "intervened, separated the residents, notified me immediately, do an incident report, document, and notify the family and the MD."</p> <p>- She was not sure if the MD had been notified.</p> <p>- She returned to work on 12/07/15 "I didn't do any kind of investigation or anything as Resident #5 was out of the building and I figured it was done. I usually do an investigation, but for this I didn't".</p> <p>- She confirmed there was no documentation about Resident #5's adjustment problems, roommate problems nor threatening behavior towards her roommate.</p> <p>- "Staff removed the razors and thought they had removed the threat."</p> <p>Interview on 12/10/15 at 4:00pm with the Health and Wellness Director revealed:</p> <p>- She is a Registered Nurse and is new to the facility as of the end of November.</p> <p>- She had been at the facility approximately one week when the incident occurred.</p> <p>- The morning of 12/04/15 when she came in at 8:00am she was aware of Resident #5's threat to her roommate in their morning meeting.</p>	{D 338}		

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{D 338}	<p>Continued From page 8</p> <ul style="list-style-type: none"> -She did not assess the resident or the roommate as she had only been employed for a week. -She spoke with the Administrator by phone around noon and was instructed to send Resident #5 out to the emergency room because of her falls and change in behavior <p>Refer to Interview on 12/11/15 at 10:39am with Staff A Personal Care Assistant.</p> <p>Interview with staff at the Physician's office on 12/14/15 at 3:00pm for Resident #5's revealed:</p> <ul style="list-style-type: none"> -The physician had not been notified by the facility regarding resident's change in behavior and the two falls on 12/4/15. -Resident's family member called physician at home on the night of 12/4/15 and informed her of resident's admission to the hospital. <p>Interview on 12/11/15 at 10:39am with Staff A personal care aide (PCA) revealed:</p> <ul style="list-style-type: none"> -She works first shift 6am to 2pm. -She went into Resident #5 and #7's room to get Resident #5 up. -"She needs more help than the other residents." -She assisted Resident #5 to the bathroom and asked her to ring call bell when finished. -She spoke with Resident #7 while Resident #5 was in bathroom. -Resident #7 told her Resident #5 had been calling her names and "threatened to cut her throat with a razor". -Resident #7 was visibly shaken and stated every time she heard Resident #5 move she was awake. -"She was scared." -Resident #5 rang for assistance and she returned to bathroom to assist her. -She "removed 2 packs of razors, 1 open with one missing, 1 pack closed and then I searched 	{D 338}		

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{D 338}	<p>Continued From page 9</p> <p>the room."</p> <p>-As Staff A, PCA removed the razors, Resident #5 told her "These razors are for (Resident #7's name)."</p> <p>-I did not talk to Resident #5 about her threats at 6:15am or 10:45am but I did take her out to the great room in her wheelchair at 10:45am but at some point she rolled herself back."</p> <p>-About 10:30am Resident #5 rang call bell in her room as she had "fallen out of the wheelchair."</p> <p>-Resident #7 told her about Resident #5's comments and threat again.</p> <p>-I did not confront her about her threats. Resident #5 wasn't agitated any more than she always was. She wasn't any more confused that day than her usual, Resident #5 was the same as she always was."</p> <p>-About lunch time Staff B told me not to take Resident #5 to lunch as "her family wanted her to go to the hospital".</p> <p>-She did not check back with Resident #7 about any further issues on 12/04/15 other than the initial time that morning.</p> <p>A Plan of Protection was provided by the facility on 12/10/15 as follows:</p> <ul style="list-style-type: none"> -Educate associates on reporting resident to resident contact immediately. Investigate and follow-up with any incidents that occur. -Educate residents about resident rights and what grievance policy is. -Ombudsman to train residents and staff. Talk to every resident weekly about concerns they may have. 	{D 338}		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	<p>Continued From page 10</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to assure Seroquel was administered as ordered by the licensed prescribing practitioner and in accordance with the facility policies and procedures for 1 of 6 residents (#1).</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 06/13/15 revealed: -Diagnoses included: Hypertension, Alzheimer's, coronary artery disease, osteoporosis, hyperlipidemia, chronic urinary tract infection. -A physician's order for Seroquel 50 mg twice daily. -Review of Physician/Healthcare Provider Visit Form, dated 10/06/15 documented a subsequent Seroquel order "Seroquel 50mg at bedtime only" signed by the attending physician.</p> <p>Confidential interview with a family member on 12/08/15 at 11:21am revealed: -The facility received an order to change the dosage for Seroquel. -Family member was informed by a staff member that the dosage was not changed in accordance with the order.</p>	D 358		

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D 358	<p>Continued From page 11</p> <p>Review of the October 2015 Medication Administration Record (MAR) on 12/09/15 revealed:</p> <ul style="list-style-type: none"> -An entry for Seroquel 50 mg. twice daily. -The Seroquel was scheduled to be administered daily at 8:00am and 8:00pm. -There was a hand written note over the entry: "see new order". -The 8:00pm administration time was crossed out and replaced with 6:00pm administration time. -The Seroquel was documented as administered twice daily from 10/01/15 through 10/28/15. -It was unclear if the second daily administration of Seroquel was at 6:00pm or 8:00pm. -There was a handwritten entry for Seroquel 50 mg one time a day at bedtime 8pm. -The Seroquel was documented as administered once daily at 8:00pm from 10/29/15 through 10/31/15. <p>Review of a physician's order in the record dated 10/29/15 at 3:00am revealed a medication change for Seroquel 50 mg from twice daily to once daily.</p> <p>A confidential interview with a Medication Aide on 12/09/15 at 5:15pm revealed:</p> <ul style="list-style-type: none"> -The Medication Aide along with a second Medication Aide read the 10/06/15 order for Seroquel, differently, due to the physician's handwriting. -The second Medication Aide read the physician's order as: "Please give Seroquel 50 mg at bedtime early." -The second Medication Aide implemented this order on the MAR on 10/06/15. - On 10/29/15 the first Medication Aide who initially transcribed the physician's order and read it as "Please give Seroquel 50 mg at bedtime early", obtained a medication clarification order 	D 358		

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 R 12/14/2015
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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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(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 358	Continued From page 12 for "Seroquel 50mg at bedtime only". - The order clarification was implemented on the MAR on 10/29/15.	D 358		
{D914}	G.S. 131D-21(4) Declaration of Residents' Rights 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. This Rule is not met as evidenced by: Based on observations, interviews and records reviews the facility failed to assure all residents were free from verbal abuse related to residents rights. The findings are: Based on observations, interviews and record reviews, the facility failed to assure 1 resident (Resident #7) was free from mental abuse from another resident (Resident #5). [Refer to Tag 0338, 10A NCAC 13F .0909 Residents' Rights (Type Unabated A2 Violation)].	{D914}		

The following is the Plan of Correction for Lenoir Park. This Plan of Correction is in response to the Statement of Deficiencies resulting from a state survey on December 9 and 10, 2015. 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.

STATEMENT OF DEFICIENCIES

Tag 0338 D914: 10A NCAC 13F .0909 Resident Rights

1. ED will provide education to associates related to reporting of incidents of resident to resident or resident to staff aggression immediately.
2. The community will investigate and follow up any incidents reported and will follow state guidelines for reporting to the county or state.
3. Residents will be educated regarding resident's rights and the grievance policy. All residents will be informed of an open door policy to voice their concerns to the ED or other management staff.
4. The ombudsman will provide follow up training on 2/5/16 for our residents.
5. Ongoing training will be provided to associates during Foundations prior to resident contact and yearly by the community.
6. The ED and designee will meet with all residents individually prior to 1/15/16 to discuss concerns. The ED and Designee will meet with all residents individually each week for four weeks to discuss concerns. After the four week period, the ED or designee will meet with all residents as a group monthly to discuss concerns.

Directed date of completion: 1/15/16

Tag D358: 10A NCAC 13F. 1004a Medication Administration

1. Random MARs will be audited daily by the Med Aides to ensure accuracy.
2. The HWD/Designee will audit random MARs weekly and completely the ME and U audit tool.
3. The audit tool will be forwarded to the DDCS weekly for four weeks and then monthly.
4. New Order tracking forms will be implemented and all medication staff will be trained/retrained on the proper use of the New Order tracking forms.
5. The HWD/Designee will monitor the New Order tracking forms on a daily basis.
6. The ED will audit the New Order tracking forms once per week for four weeks and then as needed. New Order tracking forms are to be discarded quarterly.

Date of completion: 2/15/16

Karen Phoenix 1-12-16