PRINTED: 08/06/2015 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN C)F CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLE	:160
		HAL090007	B. WING		07/2	3/2015
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
BROOKDA	ALE UNION PARK	1316 PATTI MONROE, I	ERSON AVENU NC 28112	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	The Adult Care Licens	sure Section conducted an 1/15-7/23/15.				
D 137	10A NCAC 13F .0407 Qualifications	7(a)(5) Other Staff	D 137			
	(a) Each staff person shall:	7 Other Staff Qualifications n at an adult care home				
		tiated findings listed on the n Care Personnel Registry 1E-256;				
	review, the facility fail (Staff A) had no subsi the North Carolina He	ns, interviews, and record led to ensure 1 of 3 staff tantiated findings listed on				
	The findings are:					
		ersonnel record revealed: a Personal Care Aide (PCA)				
	with activities of daily personal care and su					
		nentation of a HCPR check.				
	Administrator reveale					
	because she was not to the residents.	not performed on Staff A administering medications				
		all employees working within ired to have a HCPR check				

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

(X6) DATE TITLE

DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL090007	B. WING		07/2	3/2015
IDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
UNION PARK			JE		
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE
rior to hire. The Business Office of sponsible for checking the was responsible necks were completed terview on 07/22/15 ffice Coordinator reveals and the sponsible secause she was hire ended in the sponsible secause she was hire ended in the sponsible was not aware and facility were requiration to hire. The was responsible she was responsible deministrator. The was responsible she checked the HCland no substaintiated for 1/22/15. The terview on 07/22/15 evealed: The was not aware of the daily responsibility that the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the daily responsibility that the she was not aware of the she was not aware aw	Coordinator was ng the HCPR on new hires. for making sure the HCPR ed on new hires. at 11:20 am with Business realed: a HCPR check on Staff A d as a PCA and would not to the residents. Il employees working within red to have a HCPR check for checking the HCPR on d the information to the for staff file audits. PR for Staff A during survey findings were noted on at 12:00 pm with Staff A f the HCPR requirement ties included assisting with	D 137			
upervision OA NCAC 13F .0901 upervision O Staff shall provide ccordance with each	Personal Care and supervision of residents in resident's assessed needs,	D 270			
	DEFICIENCIES ORRECTION JORRECTION JORREC	TOTAL STREET ADDRESS OR SUPPLIER TUNION PARK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Pontinued From page 1 Tor to hire. The Was responsible for making sure the HCPR on new hires. He was responsible for making sure the HCPR or	DEFICIENCIES ORRECTION (X1) PROVIDER/SUPPLIER (X2) MULTIPLE A BUILDING: HAL090007 B. WING JUNION PARK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DITION TO THE CONTINUE OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DISTRIBUTION TO THE CONTINUE OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DISTRIBUTION TO THE CONTINUE OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY INFORMATION) DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY INFORMATION DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY INFORMATION) DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY INFORMATION DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY INFORMATION) DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY INFORMATION DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY INFORMATION DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY INFORMATION DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY INFORMATION DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY INFORMATION DISTRIBUTION TO THE PRECEDED BY FULL REGULATORY INFORMATION DISTRIBUTION TO THE ABUIL	DEFICIENCIES ORRECTION (X1) PROVIDERSUPPLIER (DIA DIDENTIFICATION NUMBER (DENTIFICATION NUMBER) HAL090007 STREET ADDRESS, CITY, STATE, ZIP CODE 1316 PATTERSON AVENUE MONROR, NC 28112 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) DITION PRICE (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) DITION DITION DITION OF THE APPROPRIES (EACH DEFICIENCY) DITION DITION OF THE APPROPRIES (EACH DEFICIENCY) DITION DITION OF THE APPROPRIES (EACH DEFICIENCY) TAKES LACE TO THE APPROPRIES (EACH D	DEPICIENCIES ORRECTION (X1) PROVIDERSUPPLIER DENTIFICATION NUMBER: HAL090007 STREET ADDRESS, CITY, STATE, ZIP CODE 1316 PATTERSON AVENUE MONROE, N. C 28112 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DIT OT to hire. The Business Office Coordinator was sponsible for checking the HCPR on new hires. The was not aware all employees working within a facility were required to have a HCPR check bor to their. The was not aware all employees working within a facility were required to have a HCPR check into to hire. The was not aware all employees working within a facility were required to have a HCPR check into the intension to the trainistrator. The was responsible for checking the HCPR on with ires and reported the information to the diministrator. The was not aware of the HCPR requirement for to employment. The value of the HCPR requirement for to employment. The value of the HCPR requirement for to employment. The value of the HCPR reduirement for to employment. The value of the HCPR reduirement for to employment. The value of the HCPR reduirement for to employment. The value of the HCPR reduirement for the residents. ANCAC 13F0901 (b) Personal Care and uppervision of residents in coordance with each residents assessed needs.

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STATE FORM 8FE211 If continuation sheet 2 of 31

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL090007	B. WING		07	//23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		1316 PA	TTERSON AVENUE			
BROOKD	ALE UNION PARK	MONRO	E, NC 28112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 2	D 270			
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility fa	ns, interviews, and record ailed to provide supervision in behaviors, inappropriate d other residents' fear of one (Resident #4).				
	The findings are:					
	6/16/15 revealed: -Admitted to the facili -Diagnoses included hypertension, and an -Documented recommassisted livingA physican order for	mental impairment,				
	notes revealed: -Documented on 6/24 was agitated, banged -Documented on 6/27 pm Resident #4 beat lunch meal and bang supperDocumented on 6/30 used inappropriate la residents as well as t -Documented on 6/30 Director had ask Res to not "speak like tha -Documented on 6/30	0/15 at 1:00 pm the Activity sident #4 to calm down and t".				

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
			5			
		HAL090007	B. WING		07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE ZIP CODE		
TO WILL OF TH	TO VIDER OR OUT FEEL		, ,	,		
BROOKD	ALE UNION PARK		TERSON AVEN	UE		
		MONROE	NC 28112			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF		COMPLETE DATE
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D 270	Continued From page	e 3	D 270			
	inappropriate languag					
		1/15 at 1:00 pm Resident #4				
		elled profanity at staff during				
	his medication time w	hich upset several				
	residents.					
	-Documented on 7/14	l/15 at 1:00 pm Resident				
	was redirected and es	scorted into the dining room.				
	-Documented on 7/14	/15 at 1:00 pm Resident #4				
	continued to bang on	the table at lunch as well as				
	on his glass with his e					
		5/15 at 4:40 pm Resident #4				
	was witnessed touchi	•				
	inappropriately.	ng a female recident				
		5/15 at 4:40 pm Resident #4				
		by the Administrator and the				
		-				
	Health and Wellness	* *				
	inappropriate behavio					
	-Documented on 7/15					
		nappropriately touched a				
	female resident.					
		3/15 at 10:00 am Resident				
	#4 continued to follow	behind the female resident				
	he touched inappropr					
	-Documented on 7/17	7/15 at 10:30 am the				
	physican office was c	ontacted in regard to the				
	Resident #4's behavio	ors.				
	-Documented on 7/20	0/15 at 2:00 pm Resident #4				
	was found in the lobb	y with the female resident				
		propriately on 7/15/15, he				
		e staff back to his room.				
		Resident #4 actions during				
	the encounter with the	9				
	7/20/15.	o iomaio resident on				
	1140/10.					
	Attompt on 7/24/45 -4	11:30 am to intonvious				
	-	t 11:30 am to interview				
	Resident #4 revealed	ne declined to be				
	interviewed.					
	Observation on 7/21/	15 at 11:30 am of Resident				

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#4 revealed he appeared irritated, upset, stared

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BOILDING			
		HAL090007	B. WING		07	/23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
		1316 PAT	TERSON AVENU	E		
BROOKD	ALE UNION PARK	MONROE	E, NC 28112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 4	D 270			
	at the surveyor and s	hook his head.				
	dated 7/15/15 for ResAn incident report was 3:00 pmDocumented Reside Business Office Manafemale resident on he her on her lipsDocumented Reside the inappropriate ber family was called on -Documented the Advivere notified by the EDocumented the psy	ent #4 was witnessed by the ager (BOM) touching a er leg and chest, then kissed ent #4 was spoken to about navior by the BOM and his 7/15/15. ministrator and the nurse				
	revealed: -A psychiatric consult the facility contract psychocumented Reside irritable and did not rethe female resident or episodes) nightly and treat mood disorders. -An order for laborate (help to determine the behaviors) and a uring energy and a uring energy and energy	ent #4 was disorganized and ecall inappropriately touching on 7/15/15. Itions of Seroquel 25 mg (a treat acute manic di Depakote 250 mg (used to s) two times daily. Fory studies of ammonia level e cause of changed				

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place only.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE S	
		HAL090007	B. WING		07/2	23/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE UNION PARK		TTERSON AVENU	UE		
	OLUMBA DV OT		E, NC 28112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 270	Continued From page	e 5	D 270			
	-Mood was documen	ted as manic, irritable.				
	sexual behaviors tow 7/15/15 in the common residents in the faci concerned and very sure art of the facility Resident conducted daily stand to discuss issues in the behaviors were discurbed in the facility of the facility resident for the facility resi	o) revealed: ident #4's had inappropriate ard a female resident on on area at the facility. lity had told her they were scared of Resident #4. Care Coordinator (RCC) d-up meetings with the staff he facility, Resident #4's assed as well as to monitor ated for Resident #4 on hed a female resident 1 care for Resident #4 as your eyes on him, so we the time". d and had "a smart mouth". of Resident #4 nor was she				
	resident involved in the behavior incident that revealed:	at 11:00 am with the female ne inappropriate sexual toccurred on 7/15/15				
	nice to herShe had spoken to h interesting to talk toShe could not recall he hadHe had never touche	his name nor what color hair ed her inappropriately. the date, year, or month, nor				
	Review on 7/22/15 of	the female resident				

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involved in the inappropriate sexual behavior

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			561251146		
		HAL090007	B. WING		07/23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
BROOKDA	ALE UNION PARK		TERSON AVENU	JE	
		MONROE	, NC 28112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 6	D 270		
	incident that had occurred on 7/15/15 current FL2 dated 4/7/15 revealed diagnoses that included dementia and depression.				
	Telephone call on 7/2 Resident #4's family v	2/15 at 10:30 am with was unsuccessful.			
	Interview on 7/23/15 at 8:40 am with a Personal Care Aide (PCA) revealed: -She was aware Resident #4 had inappropriately				
	touched a female residentResident #4 was to be monitored at all times,				
		'. eased staffing on night shift Resident #4 more closely.			
		o female residents that			
	stayed in her room m -She had spoken to the	of the female residents' ore often in the past month. ne Business Office Manager			
	residents' concerns o -She denied being sc				
		15 at 9:00 am of Resident ressed and laid across his			
	Interview on 7/23/15 a revealed:	at 9:30 am with one resident			
	-She was fearful of Re- Resident #4 told her at night to see her.	esident #4. he would come to her room			
	-She told him she had in the leg.	d a gun and would shoot him			
	were scared of him.	her female residents who			
		taff escorted one female because she was scared of			

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Resident #4.

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		HAL090007	B. WING		07/2	3/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		1316 PAT	TERSON AVEN	UE		
BROOKD	ALE UNION PARK	MONROE	, NC 28112			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ıp.	PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETE DATE
D 270	Continued From page	e 7	D 270			
	resident revealed: -She was hard of hea -She kept her door lo -She did not feel safe facilityResident #4 lived dir her roomResident #4 had mar comment several wee -Resident #4 told her midnight in her roomShe was afraid to go Resident #4 was in th -Resident #4 placed of and turned the wreath doorShe told family and f concerns for her safe -Staff walked her bac Resident #4 was in th watch from the nurse to her roomShe had not spoken safety concerns until Interview on 7/23/15 resident revealed: -She was scared arouResident #4 was rud resident, "He played of -Another female resid did not come out of h -I have walked her bac -She was kared arou- Resident #4 was rud resident, "He played of -Another female resid did not come out of h -I have walked her bac	cked at all times. with Resident #4 in the rectly across the hall from de an inappropriate eks ago. he would like to visit her at o out of her room when he hallway. candy wrappers on her door h around that hung on her friends in the facility about tty. ck to her room when he hallway or they would s station until she had gotten to the Adminstrator with her about 2 weeks ago. at 10:30 am with a third und Resident #4. le and touched a female with her leg". dent was scared of him and her room very much. heack to her room because she ent #4, he lived across the				

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NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER BROOKDALE UNION PARK THE TADDRESS. CITY, STATE, 2IP CODE 1316 PATTERSON AVENUE MONROE, NC 28112 PROVIDER SPUNDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 2IP CODE 1316 PATTERSON AVENUE MONROE, NC 28112 PROVIDER SPUNDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 2IP CODE 1316 PATTERSON AVENUE MONROE, NC 28112 PROVIDER SPUNDER SPUNDER OR CORRECTION (SCAL IDENTIFICATION AVENUE FROM STATE AND AVENUE MONROE, NC 28112 PROVIDER SPUNDER SPUNDER OR CORRECTION (SCAL IDENTIFICATION AVENUE MONROE, NC 28112 PROVIDER SPUNDER SPUNDER OR CORRECTION (SCAL IDENTIFICATION AVENUE MONROE, NC 28112 PROVIDER SPUNDER SPUNDER OR CORRECTION (SCAL IDENTIFICATION AVENUE MONROE, NC 28112 PROVIDER SPUNDER SPUNDER OR CORRECTION (SCAL IDENTIFICATION AVENUE GROSS-REFERENCED TO THE APPROVEMENT CROSS-REFERENCED TO THE APPROVEMENT CROSS	DIVISION C	of Health Service Regu	lation				
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NAME OF PROVIDER OR SUPPLIER BROOKDALE UNION PARK 1316 PATTERSON AVENUE MONROE, NC 28112 MA ID PREPRY SUMMARY STATEMENT OF DEFICIONISES PROJECTED BY AUGUST CORPORATION PREPRY PROVIDERS PLANDE CORPORATION PROVIDERS PLANDE COR	AND PLAN C)F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	:TED
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MONTO. N. 28112 SUMMARY STATEMENT OF DEFICIENCIES DEPARTMENT OF DEFICIENCY MAST BE PRECEDED BY PLLI, TAG			HAL090007			07/23	3/2015
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MONROE, NC 28112 SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PERCEPED BY FULL PREFIX TAG			1316 PAT	TERSON AVENU	UE		
Description	BROOKDA	ALE UNION PARK	MONROE	, NC 28112			
PREFIX TAG D 270 Continued From page 8 Interview on 7/22/15 at 11:05 am with the Resident Care Coordinator (RCC) revealed: -She recalled the incident on 7/15/15 when Resident #A had touched the female resident inappropriatelyShe separated Resident #4 and the female resident inappropriatelyThe pad initiated 1 on 1 care for Resident #4 on 7/17/15 which included documentation that 30 minute checks had been completedThe facility increased staff on night shift between 10:00 pm to 6:00 am to monitor Resident #4, it was the primary assignment that staff person had during that timeDuring the day it was everyone's responsibility to watch Resident #4 which included housekeeping, nursing, management, dietary aides, MA's and PCA'sShe was made aware of a female resident two was scared of Resident #4 abut 2 weeks agoThe Business Office Manager (BOM) had showed/ offered to move the female resident to another room away from Resident #4. Interview on 7/22/15 at 5:00 pm with a second PCA revealed: -She worked the 10 pm to 6:00 am shift at the facility on 7/21/15 alsoShe and Resident #4 worked puzzles and watched television on 7/21/15 in the common areaThe increased supervision and additional staff person started on 7/17/15, -she documented 30 minutes checks on Resident #4 s 30 minute check/	(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	ıN.	(VE)
D 270 Continued From page 8 Interview on 7/22/15 at 11:05 am with the Resident Care Coordinator (RCC) revealed: -She recalled the incident on 7/15/15 when Resident 4 had touched the female resident inappropriatelyShe separated Resident #4 and the female resident inappropriatelyShe separated Resident #4 and the female resident, and called the families of both residentsThey had initated 1 on 1 care for Resident #4 on 7/17/15 which included documentation that 30 minute checks had been completedThe facility increased staff on right shift between 10:00 pm to 6:00 am to monitor Resident #4, it was the primary assignment that staff person had during that timeDuring the day it was everyone's responsibility to watch Resident #4 which included housekeeping, nursing, management, dietary aides, MA's and PCA'sShe was made aware of a female resident who was scared of Resident #4 about 2 weeks agoThe Business Office Manger (BOM) had showed offered to move the female resident to another room away from Resident #4. Interview on 7/22/15 at 5:00 pm with a second PCA revealed: -She worked the 10 pm to 6:00 am shift at the facility on 7/21/15 alsoShe and Resident #4 had worked puzzles and watched television on 7/21/15 in the common areaThe increased supervision and additional staff person started on 7/17/15She documented 30 minutes checks on Resident 44's 30 minute check/							
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Division of Health Service Regulation

-The 30 minute checks were initated on 7/17/15

STATE FORM 8FE211 If continuation sheet 9 of 31

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HAL090007	B. WING		07/23/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE,	ZIP CODE	1 0772372013
TANKE OF TROVIDER OR OUT EIER	1316 PATTERSON AVENUE		
BROOKDALE UNION PARK	MONROE, NC 28112		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU TAG REGULATORY OR LSC IDENTIFYING INFORMATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE COMPLET
at 3:00 pm. -Documented 258 opportunities for 30 minut checks from 7/17/15 at 3:00 pm to 7/22/15 at 4:00 pm, 30 minute checks were not completed for 16 times during monitoring of Resident # -On 7/20/15 incomplete documentation of 30 minutes checks at 4:00 pm through 9:30 pm -On 7/21/15 incomplete documentation of 30 minute checks at 12:00 pm through 1:30 pm Interview on 7/22/15 at 2:30 pm with the Bust Office Manager (BOM)revealed: -She was aware Resident #4 was to be more due to he had inappropriately touched a femore resident. -The staff were to know where Resident #4 at all times. -She was made aware of a female resident was fearful of Resident #4 two weeks ago. -She offered to move the female resident to another room away from Resident #4. -She had not spoken to the family of the femore resident nor had the family spoken to her ab concerns for safety. Inteview on 7/22/15 at 2:45 pm with the Administrator revealed: -The nurse assessed Resident #4 before his admission to the facility. -She was aware Resident #4 had touched a female resident inappropriately on 7/15/15 at facility. -She had spoken to Resident #4's family and informed this was a new behavior for Resident #4. -She was aware staff watched him closely a extra staff was provided at night to sit with Resident #4. -She was aware last week of a female resident who had concerns Resident #4 had placed on the place of the place	at eted 44. 00 1. 00 1. 00 1. siness nitored nale was who nale bout s at this d was ent nd ent		

Division of Health Service Regulation

STATE FORM 8FE211 If continuation sheet 10 of 31

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL090007	B. WING		07/2	3/2015
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	·		
BROOKD	ALE UNION PARK		NC 28112	, -		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page 10		D 270			
	aroundShe reinforced to the watched Resident #4 resident she was safe -She had not notified resident, nor had the any safety concernsShe was aware Resi psychiatrist on 7/21/1 dementia and 2 new mood/behaviors were -The first time the psy was on admission for -They would re-evaluate the effectiveness the	the family of the female family contacted her with dent #4 had seen the 5 and a new diagnosis of medications for initated. The initated in the				
	7/23/15 which included Immediate staff will provided the supervision for 14 days Resident #4Psychiatrist evaluation completed as of 7/21/21 will be evaluatedAfter 14 days of median re-evaluated for further Arrange care plan monocerns, reassurant for security.	orovide 24 hour care, 1 on 1 bys or longer if indicated to on for Resident #4 has been 15 and new meds and labs dications Resident #4 will be the indication. The eetings with families to voice the, and offer to meet needs				

Division of Health Service Regulation

STATE FORM 8FE211 If continuation sheet 11 of 31

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING: _			
		HAL090007	B. WING		07/23	/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE UNION PARK		TERSON AVENI NC 28112	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
D 273	Continued From page	e 11	D 273			
D 273	3 10A NCAC 13F .0902(b) Health Care		D 273			
		2 Health Care assure referral and follow-up nd acute health care needs				
	reviews the facility fai 6 sampled residents (Resident #2) and a f	ns, interviews, and record iled to ensure referral for 1 of with a Podiatrist for nail care follow-up for 1 of 5 sampled ed blood pressures outside				
	The findings are:					
	05/27/15 revealed: -Diagnoses included dehydration, hyperka disease, and congest	ive heart failure. ni-ambulatory and needed				
	05/28/14No consent for or ph care.	2's record revealed: mitted to the facility on ysician's order for podiatrist f nail care provided by facility				

Division of Health Service Regulation

STATE FORM 8FE211 If continuation sheet 12 of 31

DIVISION	of Health Service Regu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL090007	B. WING		07/2	23/2015
NAME OF D	DOVIDED OD CUDDUED	OTDEET AS	DDECC CITY CTA	TE 710 CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
BROOKD	ALE UNION PARK		TERSON AVEN	UE		
		MONROE	, NC 28112			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEI IOIENOT)		
D 273	Continued From page	e 12	D 273			
		- · <u>-</u>				
	thickened.					
	-The resident's toena	ils on the right foot were				
	observed as follows:	The first toenail was 1/4 inch				
	thick with light brown	discoloration and extended				
	1/2 inch over the end	of the toe; the second				
	toenail was curved 1/	4 inch over the end of the				
	toe and flush with the	skin; the third toenail				
	curved over the top of	of the toe with 1/2 inch flush				
	with skin underneath	the toe; the fourth and fifth				
	toenails extended 1/4 inch over the top of the toe.					
	-The resident's toenails on the left foot were					
	observed as follows:	The first toenail was 1/2				
	inch thick, arew to the	e left of the toe instead of				
	_	d over the top and side of				
	the toe 1/2 inch and h	•				
		and fifth toenails extended				
	1/4 inch over the top					
		ritation was noted on the				
	toes.	mation was noted on the				
	1065.					
	Intoniou on 07/21/15	5 at 10:55 am with Resident				
	#2 revealed:	at 10.55 am with Resident				
		ara lana				
	-He knew his toenails					
		to cut people's toenails."				
	-He was not a diabeti					
		n to cut them before, but he				
	didn't."					
		sometimes" for nail care				
		nt his toenails cut at the				
	time.					
		07/22/15 at 8:40 am with				
	Resident #2 revealed	••				
		last time his nails were cut.				
	-He did want his nails	s cut.				
	Interview on 07/22/15	at 10:30 am with the				
	Resident Care Coord	inator (RCC) revealed:				
	-She had recently bee	en hired as the RCC.				
		diatrist come to the facility				

Division of Health Service Regulation

STATE FORM 8FE211 If continuation sheet 13 of 31

DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL090007	B. WING		07/23/2015	
NAME OF D	ROVIDER OR SUPPLIER	CTDEET AD	DRESS, CITY, STA	TE 710 CODE		
NAIVIE OF PI	ROVIDER OR SUPPLIER					
BROOKDA	ALE UNION PARK	1316 PAT	TERSON AVENU	JE		
MONRO		MONROE	, NC 28112			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(/	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE	
				DEFICIENCY)		
D 070	0 " 15	10	D 070			
D 273	Continued From page	2 13	D 273			
	every three months.					
	-The podiatrist was so	sheduled to return in				
		Sheduled to retain in				
	September.	44				
		t to a podiatrist outside of				
	the facility.					
		nedule a visit to a podiatrist				
	in the event that a res	sident needed nail care prior				
	to when the podiatrist	was scheduled to come to				
	the facilityNursing, including the RCC and Personal Care					
	Aides (PCA) were res	sponsible for identifying				
	residents that needed					
		CA's "make a list of the				
	residents that need to					
		ist of residents to be seen to				
	the podiatrist's office					
		ave a current list of residents				
		care, but "diabetics are				
	seen every three mor					
	-The facility did not ha					
		ho went to a podiatrist				
	outside of the facility	and ones that were to be				
	seen by the podiatrist	that came to the facility.				
	-She did not know if F	Resident #2 had been seen				
	by the podiatrist.					
	-She was not aware o	of Resident #2's nails				
	needing to be trimme	d.				
	3					
	Observation on 07/22	:/15 at 10:55 am in Resident				
	#2's room revealed:					
		dent #2's nails and stated				
		ntment to take him to a				
	-					
		ey need to be trimmed				
		eturns in September."				
		RCC his toes hurt "when				
	you mash it."					
	-Resident #2 agreed	to have a podiatrist provide				
	nail care.					

Division of Health Service Regulation

Interview with a Personal Care Aide (PCA) on

STATE FORM 8FE211 If continuation sheet 14 of 31

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
711272711	or definition	IDENTIFICATION NO.	A. BUILDING: _			
		HAL090007	B. WING		07	/23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE UNION PARK		TERSON AVEN	UE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
D 273	Continued From page	e 14	D 273			
D 273	07/22/15 at 11:20 am -She was assigned to #2Her responsibility wa Aide (MA) or RCC if a -She had reported to months ago" that Res -She thought a podiat nails because of how -She had also informe ago, but she could no -She had observed R in the past when it wa Telephone interview of the Podiatrist office st -They had no record of provide podiatry care -Resident #2 had not Podiatrist that visited Interview on 07/23/15 Nurse revealed: -Resident #2 had bee March 2015"The facility is respon -She had visited Resi had not noted the nee -She would be doing 07/23/15She did not know if a requested the facility Resident #2. Interview on 07/23/15	revealed: o provide care to Resident as to inform the Medication a resident needed nail care. a previous RCC "several sident #2 needed nail care. trist would need to trim his thick they were. ed a MA several months of recall which MA. esident #2 refuse nail care as mentioned to him by staff. on 07/22/15 at 2:15 pm with taff revealed: of being requested to for Resident #2. been provided care by the the facility quarterly. at 9:35 am with a Hospice en admitted to Hospice in ensible for nail care." dent #2 on 07/21/15, but ed for nail care. a "full assessment" on any other Hospice staff had to obtain nail care for at 9:50 am with the Health	D 273			
	week.	yed at the facility for one				
	-It was the responsibi Wellness Director to s					

Division of Health Service Regulation

STATE FORM 8FE211 If continuation sheet 15 of 31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			
		HAL090007	B. WING	B. WING		
NAME OF B	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZID CODE	1 0/	//23/2015
NAME OF P	ROVIDER OR SUPPLIER		TTERSON AVENUE			
BROOKD	ALE UNION PARK		E, NC 28112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 15	D 273			
	toenail care to be pro	hat Resident #2 needed vided. with the RCC and ensure				
	The Administrator was not available for interview. B. Review of Resident #3's current FL2 dated 5/7/15 revealed: -Diagnosis included Hypertension, Mitral and Aortic StenosisA physician's order for Coreg 3.125 mg (used to treat hypertension) twice daily. -Review of Resident #3's record revealed: -A physician's order dated 6/4/15 for daily blood pressure (BP) checks with parameters to recheck BP in 2 hours if systolic is greater than 160.					
	Record for May 2015 -BP checks were doc 5/31/15 with the BP r 173/82.	umented daily from 5/1/15 to anged between 134/82 to as were not done on the 164/83 and no P recheck in 2 hours. 173/82 and no				
	Record for June 2015 -BP checks were doc 6/30/15 with the BP r 195/63.	umented daily from 6/1/15 to anged between 134/75 to				

Division of Health Service Regulation

STATE FORM 8FE211 If continuation sheet 16 of 31

Division (of Health Service Regu	liation				
STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPLETED	
			A. BOILDING.			
		HAL090007	B. WING		07/2	23/2015
			!			
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		1316 PAT	TERSON AVEN	UE		
BROOKDALE UNION PARK MONROE.		, NC 28112				
	OUMMAN DV OT		·	DDO///DEDIO DI ANI OF CODDECTION		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
IAG		,	IAG	DEFICIENCY)		
D 273	Continued From page	e 16	D 273			
	documentation of a B	P recheck in 2 hours.				
		3's July 2015 Vital Signs				
	and Weight Record o					
	-BP checks were doc	umented daily from 7/1/15 to				
	7/21/15 with the BP ra	anged between 118/68 to				
	181/76.					
	-Five of 5 BP recheck	s were not done on the				
	following dates:					
	-On 7/9/15, BP was	163/74 and no				
	· ·					
	documentation of a BP recheck in 2 hoursOn 7/14/15, BP was 181/76 and no					
	· ·					
		P recheck in 2 hours.				
	-On 7/18/15, BP was					
		P recheck in 2 hours.				
	-On 7/19/15, BP was	172/75 and no				
	documentation of a B	P recheck in 2 hours.				
	-On 7/20/15, BP was	169/80 and no				
	documentation of a B	P recheck in 2 hours				
	-There were 2 days w	where there was no				
	_	aily BP check, on 7/5/15 and				
	7/17/15. It could not b					
		been done or not on these				
	dates.	been done of not on these				
	dates.					
	Povious of Posidont #	12'o July 2015 Vital Signs				
		3's July 2015 Vital Signs				
	and Weight Record o					
	,	4 and documentation of a				
		150/72. The documentation				
	was initialed by a med	. ,				
	-On 7/14/15, BP 181/	76 and documentation of a "				
	fall called EMS reche	cked at 11am" BP recheck				
	result of 139/72. The	documentation was initialed				
	by a MA.					
		80 and documentation of a				
	· ·	149/76. The documentation				
	was initialed by a MA					
	· · · · · · · · · · · · · · · · · · ·	nentation noted on the Vital				
		cord on 7/22/15 was not				
documented on the Vital Signs and Weight						

Division of Health Service Regulation

STATE FORM 8FE211 If continuation sheet 17 of 31

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S		
		HAL090007	B. WING		07/2	23/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
BROOKD	ALE UNION PARK		ERSON AVENU	UE			
		MONROE,				T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE	(X5) COMPLETE DATE	
D 273	Continued From page	e 17	D 273				
	Record when reviewe	ed on 7/21/15.					
	revealed: -She had added the r (7/22/15) on the Vital for the days that she month of July 2015She had gotten the r notes. I forgot to door rechecks until today". Review of her work n name and BP rechect and 7/20/15"I went back today at Interview with anothe revealed that she had days the BP rechecks	otes included Resident #3's k results for 7/9/15, 7/14/15, and filled in the sheet." r MA on 7/21/15 at 12:00pm in the worked on any of the					
	revealed: -"They check my BP	every morning. It is never hey recheck it if it is a little s low, but not high".					
	Interview with Reside 7/23/15 at 9:30am rev-She was not aware Edone as ordered betw-The facility had madefall on 7/14/15. She dwas related to the fall-Facility staff should band rechecks as order	ent #3's primary physician at vealed: BP rechecks are not being veen May to July 2015. The her aware of the BP and id not feel the resident's BP. The conducting BP checks ared. The BP ranges were "that					

Division of Health Service Regulation

STATE FORM 8FE211 If continuation sheet 18 of 31

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL090007	B. WING		07	//23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE		
BROOKD	ALE UNION PARK		TTERSON AVENUE E, NC 28112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From pag -Her office staff woul make an appointmer	d contact the facility staff to	D 273			
D 338	all residents guaranted Declaration of Reside and may be exercised. This Rule is not met TYPE B VIOLATION. Based on observation reviews, the facility factories ampled female residents' feather than the sample of the sample o	9 Resident Rights shall assure that the rights of eed under G.S. 131D-21, ents' Rights, are maintained d without hindrance. as evidenced by: ns, interviews, and record ailed to assure 3 of 3 dents (Resident #5, #6 and ental abuse as evidence by	D 338			
	6/16/15 revealed: -Diagnoses included hypertension, and ar -Recommended leve Review of the Reside revealed an admission 6/24/15. Review on 7/21/15 on notes revealed: -Documented on 6/2 was agitated, banged					

Division of Health Service Regulation

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BOILDING.			
		HAL090007	B. WING		07/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BROOKDA	ALE UNION PARK		ERSON AVENU	JE		
		MONROE,	NC 28112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	e 19	D 338			
	whole lunch meal and after supper. -Documented on 6/30 used inappropriate lair residents as well as the discontinuity of the language of the	2/15 at 1:00 pm the Resident Care Coordinator of Resident #4's ge. 4/15 at 1:00 pm Resident #4 elled profanity at staff during which upset several 4/15 at 1:00 pm Resident #4 the table at lunch as well as eating utensils. 5/15 at 4:40 pm Resident #4 ing a female resident 6/15 at 10:00 am Resident behind the female resident riately on 7/15/15. 0/15 at 2:00 pm Resident #4 by sitting with the female ned inappropriately on rected by the staff back to				
	revealed: -A psychiatric consult the facility contract psychocumented Reside	completed on 7/21/15 by sychiatrist. nt #4 was disorganized and				
	the female resident of -An order for medicat anti-psychotic used to	ions Seroquel 25 mg (a o treat acute manic I Depakote 250 mg (used to				

Division of Health Service Regulation

STATE FORM 8FE211 If continuation sheet 20 of 31

Division of	Health Service Regu	lation				
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL090007	B. WING		07/2	3/2015
NAME OF PRO	OVIDER OR SUPPLIER		DDRESS, CITY, STA	,		
BROOKDAL	LE UNION PARK		TERSON AVENU	JE 		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338 (Continued From page	20	D 338			
((help to determine the behaviors) and a uring hehaviors) and a uring hehaviors. -New diagnosis include the determined exam include the determined examined ex	alysis. ded severe dementia with ed documentation Resident veled, guarded, and hostile. umented as cooperative. umented as to person and ted as manic, irritable. 7/22/15 at 10:40 am with a). 7/22/15 at 11:05 am with the inator (RCC). 7/23/15 at 8:40 am with the PCA). 7/22/15 at 11:05 am with the				

6/20/14.

revealed an admission date to the facility on

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL090007	B. WING		07/23/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE UNION PARK	1316 PATT	ERSON AVENU	JE		
MONROE,			NC 28112		T T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	21	D 338			
	#5 revealed: -She was scared to be (Resident #4) that live -The male resident wa another female resided: -A female resident (R him and did not come -"I walked Resident # she was scared of the across the hall from heshe had not spoken about her concerns for the	as rude and touched ent, "He played with her leg". esident #6) was scared of out of her room very much. 6 back to her room because e male resident, he lived eer." to staff or the Administrator or safety. of Resident #6's current vealed: hyperthyroidism, coronary verticulitis. esident #6 was ambulatory. imitation was documented esident was oriented. nt Registry for Resident #6 n date to the facility on 15 during initial tour between am revealed Resident #6's Resident #6 did not answer inocked on door. 15 at 12:00 pm second desident #6 revealed door ousekeeper said Resident #6 and opened the door after				

Division of Health Service Regulation

Interview on 7/22/15 at 12:00 pm and on 7/23/15

STATE FORM 8FE211 If continuation sheet 22 of 31

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLI	
			P WING			
		HAL090007	B. WING		07/2	23/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE UNION PARK		ERSON AVENU	JE		
		MONROE,	NC 28112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	22	D 338			
	at 10:10 am with Res-She was hard of head door lockedShe had expressed f (Resident #4) directly roomThe male resident had monthThe male resident had comment to Resident he would like visit her-Resident #6's daugh residents' family were resident made the ina-Resident #6 told him-The male resident wowhen Resident #6 was scared to go outThe male resident pl door and turned the wher doorShe had spoken to the (BOM) and staff about concerns that candy whad been turned arout concerns that candy whad been turned arout concerns that candy whad been turned arout she had not spoken until last week of the made about coming in the assisted to her fear of the male she did attended act go out of her roomShe was aware the roomShe was aware the room inappropriately touched week.	dident #6 revealed: aring and always kept her fear of the male resident across the hall from her ad lived at the facility for a ad made an inappropriate at #6 several weeks ago that an in her room at midnight. ater as well as the male appropriate comment. ano, and was very upset. as in the hallway sometimes as leaving room, and she is acced candy wrappers on her acced candy wrappers a				
	closely					

Division of Health Service Regulation

-She knew of 2 other female residents in the

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DIVISION	n Health Service Regu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						
		HAL090007	B. WING		07/2	23/2015
			1.		·	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
DD00KD	N E UNION BARK	1316 PAT	TERSON AVEN	UE		
BROOKDA	ALE UNION PARK	MONROE	NC 28112			
	OLIMANA DV OT			DROVIDEDIO DI ANI OE CODDECTIO		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
170		,	IAG	DEFICIENCY)		
			+			
D 338	Continued From page	23	D 338			
	facility who were scar	ed of the male resident.				
	Interview on 7/22/15 a	at 1:45 pm with Resident				
	#6's family member re	evealed:				
	-She visited Resident	#6 weekly.				
		the male resident (Resident				
		priate comment several				
		snate comment several				
	weeks ago.					
	-She was not present at that visit but another					
	family member was.					
		6 was very uncomfortable				
	around him, "scared".					
	-She had not spoken	to the Administrator or any				
	staff with her concern	s or safety for Resident #6				
		any family member had				
	spoken to the Adminis	-				
	oponom to the manning	strator.				
	Interview on 7/22/15	at 2:10 pm with Booldont #6				
		at 2:10 pm with Resident #6				
	other family member					
		ocked her door due to the				
	valuables in her room					
	-She was present on	the day the male resident				
	(Resident #4) made tl	he inappropriate comment				
	to Resident #6.					
	-The male resident (R	Resident #4) had made the				
	comment that he wou	ld like to be invited in				
	Resident #6's room a					
		family were present at that				
	time also.	army were present at that				
		male resident "NO"				
	-Resident #6 told the					
		en the male resident very				
		aid he might try to come in				
	her room.					
	-In the past month Re	esident #6 stayed in her				
	room more and had n	ot been as social.				
	-She had not spoken	to any one at the facility				
		nsure if Resident #6 had				
	either.					
	Giuloi.		1			1

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Refer to interview on 7/22/15 at 10:40 am with a

STATE FORM 8FE211 If continuation sheet 24 of 31

Division C	of Health Service Regu	liation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
1141 000007		B. WING		07/23/2015			
		HAL090007	B. W		07/2	3/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		1316 PAT	TERSON AVENI	IF			
BROOKDA	ALE UNION PARK		NC 28112	<u>5</u> L			
			NC 20112				
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE	
iAo		,	IAG	DEFICIENCY)			
D 338	Continued From page	e 24	D 338				
	M = -1:4: A: -1 - (MAA)						
	Medication Aide (MA)).					
		7/22/15 at 11:05 am with the					
	Resident Care Coord	inator (RCC).					
		7/23/15 at 8:40 am with					
	PCA.						
	Refer to interview on	7/23/15 at 11:05 am with the					
	the Activity Director.						
	Refer to interview on	7/22/15 at 2:30 pm with the					
	Business Office Mana	ager (BOM).					
	Refer to interview on	7/22/15 at 2:45 pm with the					
	Administrator.	·					
	D. Review of Resider	nt #7's current FL2 dated					
	4/3/15 revealed:						
	-Diagnoses included	diabetes, chronic diarrhea,					
	hip replacement and						
		esident was oriented.					
		s were documented as sight.					
		accamenta ac e.g					
	Review of the Reside	ent Registry for Resident #7					
		on date to the facility on					
	8/2/12.	are to the radiity on					
	0/ <i>L</i> / 1 <i>L</i> .						
	Interview on 7/23/15	at 9:30 am with Resident #7					
	revealed:	at 5.50 am with resident #7					
	-She was alert and or	riented					
		a male resident (Resident					
	#4) who lived at the fa	acility. Ild her he would come to her					
	room at night to see h						
		sident, "I have a gun and					
	would shoot him in th	~					
	-The male resident ne	ever came to her room.					

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-She stated Resident #6 was afraid of the male resident, "She is scared to death of him".

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL090007	B. WING		07/2	3/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE	•	
BROOKD	ALE UNION PARK		TERSON AVENU	E		
			E, NC 28112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	25	D 338			
	-She had not told staf resident was fearful o (Resident #4).	ff she or the other female of the male resident				
	Refer to interview on Medication Aide (MA)	7/22/15 at 10:40 am with a).				
	Refer to interview on Resident Care Coord	7/22/15 at 11:05 am with the inator (RCC).				
	Refer to interview on PCA.	7/23/15 at 8:40 am with the				
	Refer to interview on 7/23/15 at 11:05 am with the the Activity Director.					
	Refer to interview on Business Office Mana	7/22/15 at 2:30 pm with the ager (BOM).				
	Refer to interview on Administrator.	7/22/15 at 2:45 pm with the				
		15 at 11:30 am the male b) was moved to a room at all 93 feet away from				
	had inappropriately to 7/15/15. -The incident happen other residents aroun -Residents' in the factivery scared of the mallin daily stand-up me) revealed: male resident (Resident #4) buched a female resident on ed in the common area with				

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behaviors.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	EIED
		HAI 000007	B. WING		07/	22/2045
		HAL090007			1 07/2	23/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
BROOKD	ALE UNION PARK		TERSON AVENU	JE		
	OLIMAN DV OT		E, NC 28112	DDOV/DEDIO DI ANI OF O	ACRRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	e 26	D 338			
	(Resident #4) closely at all times.	nitor the male resident and to know where he was 4 was loud and had "a smart at 8:40 am the PCA				
	-She was aware two of a male resident (R-She was aware one stayed in her room m-She spoken to the B (BOM) and the nurse	of the female residents' lore often in the past month. usiness Office Manager last week about the female and fears regarding the male				
	-She recalled the incimale resident (Resider resident inappropriate -They initated 1 on 1 (Resident #4) on 7/17 after the inappropriate had occurred.	linator (RCC) revealed: dent on 7/15/15 when a ent #4) touched a female				
	to 6:00 am to monitor #4)She was made awar was scared of a male about 2 weeks agoThe Business Office showed/offered to mo another room away from the process of the p	r the male resident (Resident re of a female resident who e resident (Resident #4)				

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come out of her room much in the past month.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL090007	B. WING		07/23/2015
BROOKDALE UNION PARK 1316 PATTE		DRESS, CITY, STA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 338	told her on 7/22/15 th scared to come out of male resident (Resider-She had directed the Administrator and the concerns. -She was not aware if Administrator or not of The Activity Director Administrator or the Econcerns of the family. Observation on 7/23/resident (Resident #4 the opposite end of the Resident #6's room. Interview on 7/22/15 office Manager (BON-She was aware a machad inappropriately to 7/15/15. -The staff were to know as at all times. -One female resident ago with concerns the candy wrappers on how wreath around. -The female resident resident (Resident #4 comment several were to her room at midning -She had offered to more (Resident #6) to another male resident (Resident -She had not spoken)	and her family member at Resident #6 had been for her room because of the ent #4) across the hall. It is to speak to the BOM office with their for 1/22/15. It is had not spoken to the BOM on 7/22/15 with the grand the female resident. It at 11:30 am the male grand was moved to a room at the hall 93 feet away from the hall 93 feet away from the serior of the male resident (Resident #4) the properties of the male resident on the work of the male resident (Resident #4) the male resident had placed the male and inappropriate the sago about coming over the female resident her room away from the ent #4). It to the family of Resident #6, Resident #6 spoken to her	D 338	DEL NOILING I)	

Division of Health Service Regulation

STATE FORM 8FE211 If continuation sheet 28 of 31

DIVISION	i Health Service Regu	iation				
STATEMENT OF DEFICIENCIES (X1) PI		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		-				
		HAL090007	B. WING		07/2	3/2015
NAME OF D	ROVIDER OR SUPPLIER	CTDEET AD	DRESS, CITY, STA	TE 7ID CODE		
NAME OF FI	NOVIDER OR SUFFLIER		, ,	,		
BROOKD	ALE UNION PARK		TERSON AVEN	JE		
		MONROE	NC 28112			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	٧	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
			1	DEFICIENCY)		
D 338	Continued From page	28	D 338			
	Continued From page	, 20				
	Inteview on 7/22/15 a	t 2:45 pm with the				
	Administrator reveale	d:				
	-The nurse at the faci	lity assessed the male				
) prior to his admission to				
	the facility.	, , , , , , , , , , , , , , , , , , , ,				
	-The facility was unav	ware of inappropriate				
		4 had prior to arriving at the				
		4 flad prior to arriving at the				
	facility.	dont #4 bod to cabod o				
		dent #4 had touched a				
		propriately on 7/15/15 at the				
	facility.					
		osely and extra staffing was				
	used at night to sit with Resident #4.					
	-Resident #6 had told her last week a male					
	resident (Resident #4) had placed candy					
	wrappers on her door and turned the wreath					
	around.					
	-She told Resident #6	the staff continued to				
		dent (resident #4) closely				
		ale resident she was safe in				
	the facility.	are resident site was sale in				
	-	the family of Resident #6,				
		-				
		ntacted her with any safety				
	concerns.	444 bad as an 4ba				
	-Was aware Resident					
		5 and a new diagnosis of				
	dementia and 2 new i					
	mood/behaviors were					
	_	ate Resident #4 in 2 weeks				
	the effectiveness the					
	determine if he was a	ppropriate for the current				
	assisted living facility					
	The facility provided a	a Plan of Protection on				
	7/23/15 which included the following: -Immediately the male resident (Resident #4) will					
	•	room located at the other				
	end of the hall, away					
		room with the male resident				
	for 24 hours a day starting today 7/23/15 for the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL090007	B. WING		07/23/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
BROOKD	ALE UNION PARK	1316 PATTI	ERSON AVENU	JE	
ВКООКЫ	ALL UNION FARK	MONROE,	NC 28112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 338	Continued From page	29	D 338		
D012	today 7/23/15 to discu- Increase supervision the reminder of 14 da appropriate for currer CORRECTION DATE VIOLATION SHALL N 8, 2015.	dent #6's family at 2:30 pm uss care and concerns. with the male resident for eys to determine if at facility. FOR THE TYPE B NOT EXCEED SEPTEMBER	D912		
5912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.		5012		
	This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding Supervision, and Resident Rights. The findings are:				
	The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision in regard to aggressive behaviors, inappropriate sexual conduct, and residents' fear of one other resident's behaviors (Resident #4).[Refer to Tag 0270,10A NCAC 13F. 0901(b)(Type B Violation).]				

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PRINTED: 08/06/2015 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING:			
		HAL090007	B. WING		07/2	3/2015
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE UNION PARK	1316 PATT MONROE,	ERSON AVENI NC 28112	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D912	Based on observation reviews, the facility fa sampled female resid #7) were free from members female residents' fear language by one male	ns, interviews, and record ailed to assure 3 of 3 dents (Resident #5, #6 and ental abuse as evidence by	D912			

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