	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		hal041062	B. WING		03/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
BROOKD	ALE LAWNDALE PARK		/NDALE DRIVE BORO, NC 2745	5	
(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 COMPLETE
D 000	Initial Comments		D 000		
	County Department o	sure Section and Guilford f Social Services conducted March 21-23, 2018 with an March 26, 2018.			
D 273	10A NCAC 13F .0902	(b) Health Care	D 273		
	` '	Health Care assure referral and follow-up ad acute health care needs			
	interviews, the facility notification for 1 of 5 s	ns, record reviews and failed to ensure physician sampled residents (Resident ressure (BP) results and pointments to have			
	The findings are:				
	chronic obstructive pumellitus, hypertension and goutThere was an order f	congestive heart failure, ulmonary disease, diabetes n, hyperlipidemia, obesity, for Coumadin 6 mg daily. 3's Resident Register			

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

TITLE (X6) DATE

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BROOKDALE LAWNDALE PARK 4400 LAWNDALE DRIVE GREENSBORO, NC 27455 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER BROOKDALE LAWNDALE PARK STREET ADDRESS, CITY, STATE, ZIP CODE 4400 LAWNDALE DRIVE GREENSBORO, NC 27455 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (CORRECTION)				_			
BROOKDALE LAWNDALE PARK 4400 LAWNDALE DRIVE GREENSBORO, NC 27455 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (CORRECTION (CORRECT			hal041062	B. WING		03/26/20	18
BROOKDALE LAWNDALE PARK GREENSBORO, NC 27455 (X4) ID PROVIDER'S PLAN OF CORRECTION (CORRECTION (CORR	NAME OF PROV	PROVIDER OR SUPPLIER	JPPLIER STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GREENSBORO, NC 27455 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (CORRECTION (CORR	BROOKDALE	DALE LAWNDALE PARK	ALE PARK				
(AT) ID			GREENSB	ORO, NC 2745			
	PRÉFIX	(EACH DEFICIENC	H DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE CO	(X5) MPLETE DATE
D 273 Continued From page 1 D 273	D 273 C	3 Continued From page	From page 1	D 273			
1. Review of Resident #3's physicians orders revealed: -An INR level was drawn at the providers office on 01/03/18 (INR result 2.8) and an order to recheck INR level in 2 weeks (INR due 01/17/18) (normal reference range for INR is between 2.0 to 3.0). -An INR level was drawn at the providers office on 02/19/18 (INR result 1.8) with an order to recheck INR level in one week on 02/28/18. -An INR level was order on 02/28/18. -An INR level was order on 02/28/18. -An INR level was order on 02/28/18 at the provider office (INR result 2.2) and an order to schedule an appointment to recheck the INR level in two weeks (INR due 03/14/18). Staff scheduled the appointment for INR on 03/22/18 and not for 3/14/18 (INR result 2.6). Review of Resident #3's resident notes revealed: -There was no documentation that the appointments for INR levels on 01/17/18 and 03/14/18 had been scheduled or rescheduledThere was a note documenting the resident was adamant he did not have an INR lab draw on 01/17/18 and the resident was to be seen in February 2018 instead. -There was no documentation the facility staff called to clarify the INR lab draw due on 01/17/18 with the provider's office. Telephone interview with Resident #2's Primary Care Provider's nurse on 03/23/18 at 11:15 am revealed: -The facility never called to schedule an appointment for 01/17/18 of 03/14/18 to have INR lab schawn for the residentThe resident was not known for calling and rescheduling appointmentsThe facility provided transportation to and from appointments.	1. re	1. Review of Resider revealed: -An INR level was dra on 01/03/18 (INR res recheck INR level in 2 (normal reference rar 3.0)An INR level was dra on 02/19/18 (INR res recheck INR level in 2-An INR level was dra provider office (INR reschedule an appointr in two weeks (INR duscheduled the appoint and not for 3/14/18 (INR eview of Resident # -There was no docum appointments for INR 03/14/18 had been so -There was a note do adamant he did not he 01/17/18 and the resifebruary 2018 insteadamant	of Resident #3's physicians orders vel was drawn at the providers office 8 (INR result 2.8) and an order to R level in 2 weeks (INR due 01/17/18) ference range for INR is between 2.0 to vel was drawn at the providers office 8 (INR result 1.8) with an order to R level in one week on 02/28/18. vel was drawn on 02/28/18 at the fice (INR result 2.2) and an order to n appointment to recheck the INR level ks (INR due 03/14/18). Staff the appointment for INR on 03/22/18 3/14/18 (INR result 2.6). Resident #3's resident notes revealed: a no documentation that the nts for INR levels on 01/17/18 and ad been scheduled or rescheduled. a note documenting the resident was be did not have an INR lab draw on and the resident was to be seen in 018 instead. a no documentation the facility staff arify the INR lab draw due on 01/17/18 by interview with Resident #3's Primary der's nurse on 03/23/18 at 11:15 am of never called to schedule an ant for 01/17/18 or 03/14/18 to have INR for the resident. The provided transportation to and from and appointments. In the provided transportation to and from	D 2/3			

Division of Health Service Regulation

STATE FORM 6899 WN9511 If continuation sheet 2 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		
		hal041062	B. WING		03/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
BROOKD	ALE LAWNDALE PARK		NDALE DRIVE		
		GREENSB	ORO, NC 2745	55	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
D 273	Continued From page	2	D 273		
	appointments with the	e office.			
	pm revealed: -As far as he knew his -The facility provided appointmentsThe facility sometime when his INR levels v -The resident was unsmisplaced or what the Interview with the Ass (ED) on 03/23/18 at 4 know the resident mis 2. Review of Residen revealed: -The original order to readings to the physic dated 06/25/16.	sure if the paperwork was a cause for confusion was. sociate Executive Director c:25 pm revealed she did not seed two INR lab draws. It #3's physician's orders check BP daily and send BP cian assistant (PA) was h's orders dated 09/13/17 k BP daily and send			
	Administration Record 2018, February 2018, -There was an entry the readings every 3 week. There was document been checked 82 times through March 21, 20. The resident's systol and the diastolic BP round 1/18 to 01/31/18. The resident's systol and the diastolic BP round 1/18 to 02/28/18.	tation the residents BP had es from January 1, 2018 18. ic BP ranged from 103-160 anged from 51-91 between ic BP ranged from 142-165 anged from 80-95 between			

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STATE FORM 6899 WN9511 If continuation sheet 3 of 35

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JULIPLE CONSTRUCTION (X3) DATE SUR COMPLETE		
			A. BUILDING: _			
		hal041062	B. WING		03/2	26/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE LAWNDALE PARK		NDALE DRIVE ORO, NC 2749	55		
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 273	O3/01/18 to O3/21/18. Review of Resident # there was no docume been notified of any E Interview with the Exe O3/22/18 at 5:30 pm r - She did not know ab residents BP daily an - She did not know the resident's BP reading as orderedIt was the MAs responsedents BP and sen - She expected staff to orderedWhen a new order wwas faxed to the phare entered the order into Telephone interview w#3's Primary Care Profits 11:15 am revealed: -There were no BP residented to the provider's office - The nurse did not know the BP order of it was an active order O2/20/18. Telephone interview with the phare of the provider's office - The nurse did not know the BP order of it was an active order O2/20/18.	anged from 60-90 between 3's resident notes revealed entation the provider had BP results. ecutive Director (ED) on revealed: out the order to check the disend readings to the PA. estaff were not sending the sit to the PA every 3 weeks onsibility to check the disensibility to check the di	D 273	DEFICIENCY)		
	the facility.					

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STATE FORM 6899 WN9511 If continuation sheet 4 of 35

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	TIPLE CONSTRUCTION (X3) DATE SU COMPLE		
			A. BOILDING.			
		hal041062	B. WING		03	3/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PPOOKD	ALE LAWNDALE DARK	4400 LA	WNDALE DRIVE			
BROOKD	ALE LAWNDALE PARK	GREENS	SBORO, NC 27455			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 4	D 273			
		d over the FL2 dated coked over the FL2 dated were never changed in their				
	03/23/18 at 3:30 pm of She checked Reside been sending reading. She had sent the BF could not recall the lawere sent to the provement of the followed what we she accepted responsively overlooked the instrumber BP readings to the Proceedings of the Proceedings	ent #3's BP daily, but had not gs to the PA every 3 weeks. Preadings in the past but list time the BP readings ider. Past listed on the eMAR. Insibility that she had ctions on the eMAR to send				
	3:45 pm revealed: -She did not know ab Resident #3's BP dai the PA every 3 weeks -She was not response	out the order to check ly and send BP readings to s.				
	revealed: -The facility staff chece -He did not know if the readings to the PA.	ent #3 on 03/23/18 3:50 pm cked his BP every day. e staff were sending BP sociate Executive Director				
	(ED) on 03/23/18 at 4					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	, ,	E SURVEY PLETED
		hal041062	B. WING		03	3/26/2018
	ROVIDER OR SUPPLIER ALE LAWNDALE PARK	4400 LA\	DDRESS, CITY, STATE, WNDALE DRIVE BBORO, NC 27455	ZIP CODE		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	into the facility's eMA-She did not know if the eMARs or if the contremands. To her knowledge the able to look at the oreal the completed random elements and the cliral she did not know about residents BP daily and she did not know staresident's BP reading as ordered. The facility failed to reprovider of a resident schedule appointment and transport the result appointment safety of the resident Violation. A Plan of Protection on 03/23/18 as follows.	macy did not enter orders R system. The facility printed off the facility printed off the facted pharmacy printed the econtracted pharmacy was ders in the eMAR system. It describes the contracted pharmacy was ders in the eMAR system. It does not the old the clinical support staff of the old this was the responsibility of facial support staff. Four the order to check the did send readings to the PA. The fact were not sending the gray to the PA every 3 weeks to the PA every 3 weeks to have INR levels drawn; the state of the health and and constitutes a Type B	D 273			
	-The facility will immed orders on the eMARThe facility will sched all MAs on completion order tracking form, at a -The Health and Well Resident Care Coord Resident Care Aide with tracking form as order and verification.	ediately update physicians dule mandatory retraining for n and verification of the new as well as, FL2 compliance. Iness Director (HWD),				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal041062	B. WING		03/26/2018	
	ROVIDER OR SUPPLIER	4400 LAWN	RESS, CITY, STANDALE DRIVE			
(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 273	Continued From page conduct monthly eMA CORRECTION DATE VIOLATION SHALL N 2018 .	AR audits.	D 273			
D 344	the resident's physicial for verification or clari medications and treat (1) if orders for admission admission or readmission or readmissions are not the sam The facility shall ensure	2 Medication Orders ne shall ensure contact with an or prescribing practitioner ification of orders for tments: sion or readmission of the d and signed within 24 hours mission to the facility; lear or complete; or on forms are received upon sion and orders on the	D 344			
	reviews, the facility fa the physician for clari for 1 of 5 sampled res orders for an analges The findings are: 1. Review of Residen 02/20/18 revealed dia	ns, interviews, and record iiled to assure contact with fication of medication orders sidents (Resident #3) with ic and an anti-inflammatory. It #3's current FL2 dated agnoses included congestive obstructive pulmonary				

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STATE FORM 6899 If continuation sheet 7 of 35 WN9511

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		hal041062	B. WING		03/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
PPOOKD	ALE LAWNDALE PARK	4400 LAW	NDALE DRIVE		
BROOKD	ALE LAWINDALE PARK	GREENSB	ORO, NC 274	55	
(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 COMPLETE
D 344	Continued From page	e 7	D 344		
	hyperlipidemia, obesi	ty, and gout.			
	Review of Resident # revealed an admissio	3's Resident Register on date of 10/09/15.			
	a. Review of Residen	t #3's current FL2 dated			
	02/20/18 revealed the	ere was no order for			
	acetaminophen (used twice daily.	d to treat minor pain) 325 mg			
	orders dated 02/01/18 order for acetaminoph	3's signed physician's 8 revealed there was an hen 325 mg twice daily. 3's February 2018 elecronic ation Record (eMAR)			
		or acetaminophen 325 mg			
	twice daily at 8:00 am	•			
		tation of administration at			
	-	from 02/01/18 to 02/28/18. eflect the order change on			
	the FL2 dated 02/20/	•			
	acetaminophen 325 n				
	-	3's March 2018 eMAR			
	-There was an entry f	or acetaminophen 325 mg			
	twice daily at 8:00 am				
	-There was documen	tation of administration at			
	-	from 03/01/18 to 03/21/18.			
		eflect the order change on			
	the FL2 dated 02/20/				
	acetaminophen 325 n	ng twice daily.			
	02/20/18 revealed the	t #3's current FL2 dated ere was an order for ed to treat gout) twice a day			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED
		hal041062	B. WING		03/26/2018
	ROVIDER OR SUPPLIER ALE LAWNDALE PARK	4400 LA\	DDRESS, CITY, STATE WNDALE DRIVE BORO, NC 27455		
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
D 344	order for colchicine 0. needed for gout attack Review of Resident # Medication Administration revealed there was an every 12 hours as needed for gout flate and in the pholograph of the pholograph of the colchicine 0.6 mg tall administration. Instructions were 325 administration but the colchicine 0.6 mg given needed for gout flate and the clichicine of the pholograph of the HWN) on 03/22/18 and the clichicine of the completed random endeded for gout the completed random endeded for gout the clichicine of the HWN and the clichiche was not aware to the colchiche was not aware to the colchiche of the them.	3's signed physician's 8 revealed there was an 6 mg every 12 hours as ks. 3's February 2018 electronic ation Record (eMAR) entry for colchicine 0.6 mg eded for gout attacks. 3's March 2018 eMAR entry for colchicine 0.6 mg eded for gout attacks. 3's record revealed no evisician was notified for tion orders. s on hand for Resident #3 m revealed: mg tablet was available for staff were using the entry for each of twice daily as ups. alth and Wellness Nurse at 4:05 pm revealed: mical support staff MAR audits. The compared to the old this was the responsibility of ical support person. The acetaminophen and nuing to be administered	D 344		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
	hal041062	B. WING		03	/26/2018
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	, 33	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		WNDALE DRIVE			
BROOKDALE LAWNDALE PARK	GREENS	SBORO, NC 27455			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
the HWN and the clinical -There was nothing in plaudit processShe was not aware the colchicine were continuing although they were not of 02/20/18. Interview with Resident Provider on 03/23/18 at -The provider did not was acetaminophen 325 mg -The provider did not was colchicine 0.6 mg every The provider was unaway continuing to receive the twice daily and colchicing -All orders on the FL2 where Telephone interview with pharmacy representative revealed: -The pharmacy did not ple MARs for the facility.	utive Director (ED) on realed: cal support completed compared to the old s was the responsibility of al support person. lace to keep track of the acetaminophen and ing to be administered on the FL2 dated #3's Primary Care 11:15 am revealed: ant to continue the twice daily. ant to continue the twice daily. are the resident was acetaminophen 325 mg are 0.6 mg every 48 hours. Are current and correct. In facility's contracted are on 03/23/18 at 11:45 am aprint off or manage enter or change orders for acedication orders and and ion to the facility. And looked over the direct orders were never	D 344			

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STATE FORM 6899 WN9511 If continuation sheet 10 of 35

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		hal041062	B. WING		03	3/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
BROOKD	ALE LAWNDALE PARK		WNDALE DRIVE SBORO, NC 27455			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 344	Continued From page	e 10	D 344			
	orders immediately.					
	pm revealed: -The staff administered administered administered and a staff administered and a st	sociate Executive Director on revealed: at the facility 03/12/18. macy does not enter orders em. be facility printed off the racted pharmacy printed the racted pharmacy printed the recontracted pharmacy was ders in the system. linical support completed is. re compared to the old this was the responsibility of nical support person. the acetaminophen and nuing to be administered				
D 358	10A NCAC 13F .1004 Administration	4(a) Medication	D 358			
	(a) An adult care hor preparation and adm prescription and nonby staff are in accord (1) orders by a licens which are maintained	4 Medication Administration me shall assure that the inistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and ion and the facility's policies				

Division of Health Service Regulation

STATE FORM 6899 WN9511 If continuation sheet 11 of 35

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		hal041062	B. WING		0	3/26/2018
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
BROOKD	ALE LAWNDALE PARK		WNDALE DRIVE SBORO, NC 27455			
(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 358	Continued From page and procedures.	e 11	D 358			
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility fa were administered as prescribing practition	#3) with orders for insulin, a er, a vasodilator, an				
	02/20/18 revealed dia					
	02/20/18 revealed the insulin 100 units/ml (a	nt #3's current FL2 dated ere was an order for lantus a slow-acting insulin used to sugar levels) 40 units once				
	orders dated 12/14/1 -There was an order	#3's subsequent physician's 7 revealed: for lantus insulin 100 its subcutaneously one time				
	orders dated 02/01/1 -There was an order					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		hal041062	B. WING		03/26/2018	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZID CODE	03/20/2010	
			/NDALE DRIVE	, E, ZII 600E		
BROOKD	BROOKDALE LAWNDALE PARK GREENSB			55		
(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 COMPLETE	
D 358	Continued From page	e 12	D 358			
	Medication Administrate revealed: -There was an entry funits/ml, 30 units oncome at 8:00 pm from 02/0°. The eMARS did not o02/20/18 for lantus insunits subcutaneously. The resident's blood Review of Resident # revealed: -There was an entry funits/ml, 30 units oncome at 8:00 pm from 03/0°. The eMARS did not o02/20/18 for lantus insunits subcutaneously. The resident's blood Observations of medical Resident #3 on 03/23°. Lantus insulin 100 unadministrationInstructions were to insubcutaneously once Refer to interview with nurse (HWN) on 03/20°. Refer to interview with (ED) on 03/22/18 at 5°.	for lantus insulin 100 e daily at 8:00 pm. tation of administration daily 1/18 to 02/28/18. reflect the order change on sulin 100 units/ml, inject 40 once daily on the FL2. sugars ranged from 70-267. 3's March 2018 eMAR for lantus insulin 100 e daily at 8:00 pm. tation of administration daily 1/18 to 03/21/18. reflect the order change on sulin 100 units/ml, inject 40 once daily on the FL2. sugars ranged from 84-250. cations on hand for 1/18 at 3:00 pm revealed: nits/ml was available for niject 30 units daily. In the Health and Wellness 2/18 at 4:05 pm. In the Executive Director 1:30 pm. In Resident #3's Primary				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		hal041062	B. WING		03/26/2018	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE LAWNDALE PARK		IDALE DRIVE ORO, NC 2745	55		
(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 COMPL	ETE
D 358	Continued From page	e 13	D 358			
	Refer to telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am.					
	Refer to interview with 3:50 pm.	n Resident #3 on 03/23/18 at				
	Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm.					
	b. Review of Resident #3's current FL2 dated 02/20/18 revealed there was an order for torsemide 20 mg (used to treat fluid retention) 4 tablets every morning and 2 tablets in the evening.					
		3's signed physician's 3 revealed an order for ablets twice daily.				
	Medication Administrative revealed:					
	-There was an entry for torsemide 20 mg, 4 tablets twice daily at 8:00 am and 8:00 pmThere was documentation of administration at 8:00 am and 8:00 pm from 02/01/18 to 02/28/18The eMARS did not reflect the order change on					
	02/20/18 for torsemid	e 20 mg tablets, 4 tablets tablets every evening.				
	tablets twice daily at 8 -There was document 8:00 am and 8:00 pm -The eMARS did not a 02/20/18 for torsemid	or torsemide 20 mg, 4				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		hal041062	B. WING	<u>-</u>	03	3/26/2018
NAME OF P	ROVIDER OR SUPPLIER		NDDRESS, CITY, STATE	, ZIP CODE	·	
BROOKD	ALE LAWNDALE PARK		SBORO, NC 27455			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page 14		D 358			
	-Torsemide 20 mg tal administration.	ications on hand for 3/18 at 3:00 pm revealed: olets was available for torsemide 20 mg, 4 tablets				
	Refer to interview with the Health and Wellness nurse (HWN) on 03/22/18 at 4:05 pm. Refer to interview with the Executive Director (ED) on 03/22/18 at 5:30 pm.					
	Refer to interview wit Care Provider on 03/2	h Resident #3's Primary 23/18 at 11:15 am.				
		terview with the facility's representative on 03/23/18				
	Refer to interview wit 3:50 pm.	h Resident #3 on 03/23/18 at				
	Refer to interview wit Director on 03/23/18	h the Associate Executive at 4:25 pm.				
	02/20/18 revealed the	sed to treat high blood				
	orders dated 02/01/18	3's signed physician's 8 revealed: for carvedilol 25 mg twice				
		3's subsequent physician's der dated 02/13/18 for e daily with a meal.				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		hal041062	B. WING		0:	3/26/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
BROOKD	ALE LAWNDALE PARK		WNDALE DRIVE SBORO, NC 27455				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From pag	e 15	D 358				
	Medication Administr revealed: -There was an entry daily at 8:00 am and -There was documer 8:00 am and 5:00 pm -The eMAR did not rethe FL2 dated 02/20/20/20/20/20/20/20/20/20/20/20/20/2	ntation of administration at from 02/01/18 to 02/28/18. eflect the order change on 18 for Carvedilol 12.5 mg #3's March 2018 eMAR					
	-Carvedilol 12.5 mg t administration.	ications on hand for 3/18 at 3:00 pm revealed: ablets was available for carvedilol 25 mg twice daily.					
	Refer to interview wit nurse (HWN) on 03/2	th the Health and Wellness 22/18 at 4:05 pm.					
	Refer to interview wit (ED) on 03/22/18 at	th the Executive Director 5:30 pm.					
	Refer to interview wit Care Provider on 03/	th Resident #3's Primary 23/18 at 11:15 am.					
		nterview with the facility's representative on 03/23/18					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		hal041062	B. WING		03	/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
BROOKD	ALE LAWNDALE PARK		NNDALE DRIVE BORO, NC 27455	;		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 16	D 358			
	Refer to interview with 3:50 pm.	h Resident #3 on 03/23/18 at				
	Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm.					
	02/20/18 revealed the insulin 100 units/ml (a lower elevated blood	t #3's current FL2 dated ere was an order for Novolog a fast-acting insulin used to sugar levels) 10 units three ed for blood sugar greater				
	orders dated 12/14/1 -There was an order tunits/ml, inject 6 units	3's subsequent physician's 7 revealed: for Novolog flexpen 100 s subcutaneously before ugar greater than 150.				
	orders dated 02/01/18 -There was an order tunits/ml, inject 6 units	3's signed physician's 3 revealed: for Novolog insulin 100 s subcutaneously before ugar greater than 150.				
	Medication Administrative revealed: -There was an entry funits/ml, inject 6 units meals, give if blood support -The resident's blood -Staff documented act blood sugar 28 of 84 -The eMARS did not 02/20/18 for Novolog	for Novolog flexpen 100 subcutaneously before ugar greater than 150. sugars ranged from 70-267. Iministration of Novolog for opportunities. reflect the order change on insulin 100 units/ml, inject sly before meals, give if				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		hal041062	B. WING		03/26/2018
	ROVIDER OR SUPPLIER ALE LAWNDALE PARK	4400 LAW	DDRESS, CITY, STA /NDALE DRIVE BORO, NC 274		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 358	Review of Resident # revealed: -There was an entry funits/ml, inject 6 units meals, give if blood stream of the resident's blood -Staff documented ad blood sugar 23 of 62 -The eMARS did not 02/20/18 for Novolog 10 units subcutaneous blood sugar greater the Observations of medi Resident #3 on 03/23 -Novolog insulin 100 administrationInstructions were to before meals, give if the 150. Refer to interview with nurse (HWN) on 03/2 Refer to interview with (ED) on 03/22/18 at 5 Refer to telephone into contracted pharmacy at 11:45 am. Refer to interview with 3:50 pm.	or Novolog flexpen 100 subcutaneously before ugar greater than 150. sugars ranged from 84-250. Iministration of Novolog for opportunities. reflect the order change on insulin 100 units/ml, inject sly before meals, give if man 150. cations on hand for /18 at 3:00 pm revealed: units/ml was available for inject 6 units subcutaneously blood sugar greater than the Health and Wellness 2/18 at 4:05 pm. The Executive Director 1:30 pm. The Resident #3's Primary 23/18 at 11:15 am. The Resident #3 on 03/23/18 at the Associate Executive	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		hal041062	B. WING		0:	3/26/2018
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
BROOKD	ALE LAWNDALE PARK		BORO, NC 27455			
(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 TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	e. Review of Resider 02/20/18 revealed th hydralazine hcl 25 m pressure and heart faday. Review of Resident forders dated 02/01/1 order for hydralazine day. Review of Resident forders dated 02/01/1 order for hydralazine day. Review of Resident forders dated 02/01/1 order for hydralazine day. Review of Resident forders dated for the was an entry tablet three times da 8:00 pm. -There was documer 8:00 am, 2:00 pm, an 02/28/18. -The eMAR did not rether the full forders documer for the full forders did not rether full forders did not full forders did not full full forders did not full full full full forders did not full full full full full full full ful	ant #3's current FL2 dated ere was an order for g (used to treat high blood ailure) 3 tablets three times a says signed physician's 8 revealed there was an whol 100 mg three times a says February 2018 electronic ration Record (eMAR) for hydralazine hol 100 mg illy at 8:00 am, 2:00 pm, and antation of administration at and 8:00 pm from 02/01/18 to reflect the order change on three times a day. #3's March 2018 eMAR for hydralazine hol 100 mg day. #15's March 2018 eMAR for hydralazine hol 100 mg day. #16's March 2018 eMAR for hydralazine hol 100 mg day. #17's March 2018 eMAR for hydralazine hol 100 mg day. #18's March 2018 eMAR for hydralazine hol 100 mg day. #18's March 2018 eMAR #18's March 2018 eMAR #19's March 2018 eMAR #19's March 2018 eMAR	D 358			
		lications on hand for 3/18 at 3:00 pm revealed: ng tablets was available for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		hal041062	B. WING		03	3/26/2018
NAME OF PR	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
BROOKDA	ALE LAWNDALE PARK		WNDALE DRIVE SBORO, NC 27455			
(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 358	three times a day. Refer to interview with nurse (HWN) on 03/2 Refer to interview with (ED) on 03/22/18 at 4. Refer to interview with Care Provider on 03/2 Refer to telephone in contracted pharmacy at 11:45 am. Refer to interview with 3:50 pm. Refer to interview with Director on 03/23/18 f. Review of Resident 02/20/18 revealed the acetaminophen (used twice daily). Review of Resident 4 orders dated 02/01/1 order for acetaminophen (used twice daily). Review of Resident 4 orders dated 02/01/1 order for acetaminophen (used twice daily). Review of Resident 4 orders dated 02/01/1 order for acetaminophen (used twice daily). There was an entry twice daily at 8:00 arders dated 02/01/1 order for acetaminophen (used twice daily). There was an entry twice daily at 8:00 arders	th the Health and Wellness 22/18 at 4:05 pm. th the Executive Director 5:30 pm. th Resident #3's Primary 23/18 at 11:15 am. Interview with the facility's representative on 03/23/18 at 11:45 at 4:25 pm. It #3's current FL2 dated ere was no order for d to treat minor pain) 325 mg #3's signed physician's 8 revealed there was an ihen 325 mg twice daily. #3's February 2018 eMAR for acetaminophen 325 mg	D 358	DEFICIENC		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		hal041062	B. WING		03	3/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	E, ZIP CODE		
BROOKD	ALE LAWNDALE PARK		WNDALE DRIVE BORO, NC 2745	5		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 20	D 358			
	revealed: -There was an entry fixice daily at 8:00 am -There was documen 8:00 am and 8:00 pm -The eMAR did not rethe FL2 dated 02/20/acetaminophen 325 r Observations of medial Resident #3 on 03/23-Acetaminophen 325 administrationInstructions were 32. Refer to interview with nurse (HWN) on 03/22 Refer to interview with (ED) on 03/22/18 at 53 Refer to interview with Care Provider on 03/32 Refer to telephone in contracted pharmacy at 11:45 am.	tation of administration at a from 03/01/18 to 03/21/18. Effect the order change on 18 to discontinue the mg twice daily. ications on hand for 3/18 at 3:00 pm revealed: mg tablet was available for 5 mg tablet twice daily. the Health and Wellness 1/2/18 at 4:05 pm. the Executive Director 5:30 pm. the Resident #3's Primary				
	·	h the Associate Executive at 4:25 pm.				
	02/20/18 revealed the	it #3's current FL2 dated ere was no order for ed to treat gout) every 48				

hours.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		hal041062	B. WING		0.5	3/26/2018
NAME OF P	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE	1 00	720/2010
TWAME OF T	NOVIDER OR COLL FIER		WNDALE DRIVE	, ZII OODL		
BROOKD	ALE LAWNDALE PARK		SBORO, NC 27455			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page 21		D 358			
	orders dated 02/01/1	#3's signed physician's 8 revealed there was an .6 mg every 48 hours.				
	Review of Resident #3's February 2018 eMAR revealed: -There was an entry for colchicine 0.6 mg every 48 hours. -There was documentation of administration every 48 hours from 02/01/18 to 02/28/18. -The eMAR did not reflect the order change on the FL2 dated 02/20/18 to discontinue the colchicine 0.6 mg every 48 hours. Review of Resident #3's March 2018 eMAR revealed: -There was an entry for colchicine 0.6 mg every 48 hours. -There was documentation of administration every 48 hours from 03/01/18 to 03/21/18. -The eMAR did not reflect the order change on the FL2 dated 02/20/18 to discontinue the colchicine 0.6 mg every 48 hours.					
	Observations of med Resident #3 on 03/23 -Colchicine 0.6 mg ta administration.	ications on hand for 3/18 at 3:00 pm revealed: ablets was available for 6 mg give one tablet twice				
	nurse (HWN) on 03/2	h the Executive Director				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDIEAN	or doring of the state of the s	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		LLILD
		hal041062	B. WING		03/	26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE LAWNDALE PARK		NDALE DRIVE			
	OLIMANA DV. OT		BORO, NC 274		DECTION.	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page 22		D 358			
	Refer to interview with Resident #3's Primary Care Provider on 03/23/18 at 11:15 am.					
	Refer to telephone interview with the facility's contracted pharmacy representative on 03/23/18 at 11:45 am.					
	Refer to interview with Resident #3 on 03/23/18 at 3:50 pm.					
	Refer to interview with the Associate Executive Director on 03/23/18 at 4:25 pm.					
	Review of Resident #3's current FL2 dated 02/20/18 revealed diagnoses included congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, hypertension, hyperlipidemia, obesity, and gout.					
	at 7:50 am revealed: -Carvedilol 25mg was #3 at 7:50 am by a m -The resident was in t medication cartThe prescription labe	the hallway at the				
		3's signed physician's 3 revealed that there was an 5 mg twice daily.				
	Review of Resident #	3's subsequent physician's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3			
		hal041062	B. WING		03	3/26/2018
	ROVIDER OR SUPPLIER	4400 LA	DDRESS, CITY, STATE	ZIP CODE		
		GREENS	BORO, NC 27455			
(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 358	carvedilol 25 mg twice Review of Resident # 02/20/18 revealed the carvedilol 12.5 mg (us pressure) twice daily. Review of Resident # Medication Administra revealed: -There was an entry f daily, at 8:00 am and -The eMARs did not r 02/20/18 for Carvedilol -Carvedilol 25 mg tab administered at 8:00 Interview on 3/22/18 a revealed: -She had worked in th -She read the eMAR removed the medication administration to the reading the made sure she a medications as writte Refer to interview with nurse (HWN) on 03/2	B revealed an order for e daily with a meal. 3's current FL2 dated are was an order for sed to treat high blood 3's March 2018 electronic ation Record (eMAR) For carvedilol 25 mg twice 5:00 pm. Feflect the order change on a point 12.5 mg twice daily. Fillet was documented as a am on 3/22/18. Fat 8:00 am with a MA Fine facility for 19 years. For each resident before she is in the medication as she in the medicane cup for resident. Fine facility for 19 wears. For each medication as she in the medicine cup for resident. Fine facility for 19 wears. For each medication as she in the medicine cup for resident. Fine the Health and Wellness 2/18 at 4:05 pm. Fig. 10 the Executive Director	D 358			
	Refer to interview with Care Provider on 03/2 Refer to telephone interview.	n Resident #3's Primary				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		hal041062	B. WING		03	3/26/2018
NAME ∩E P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	: 7IP CODE		
NAME OF T	NOVIDEN ON 3011 EIEN		VNDALE DRIVE	., ZII CODL		
BROOKD	ALE LAWNDALE PARK		BORO, NC 27455			
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	24	D 358			
	at 11:45 am.					
	Refer to interview with 3:50 pm.	n Resident #3 on 03/23/18 at				
	Refer to interview witl Director on 03/23/18	n the Associate Executive at 4:25 pm.				
	b. Observation of the at 7:50 am revealed:	medication pass on 3/22/18				
	-Acetaminophen 325 administered to Resid medication aide (MA)	lent #3 at 7:50 am by a				
	-The resident was in the medication cart.	•				
	-The prescription labe package read, "MAPA tablet twice daily."	AP 325 mg tablets take one				
	orders dated 02/01/18	3's signed physician's 3 revealed there was an nen 325 mg twice daily.				
	Review of Resident # 02/20/18 revealed the					
	six hours as needed f					
	Acetaminophen 325 r was not on the FL2.	ng scheduled twice daily				
	Review of Resident # Medication Administra	3's March 2018 electronic ation Record (eMAR)				
	revealed: -There was an entry f twice daily at 8:00 am	or acetaminophen 325 mg				
	-The eMARs did not r	reflect the order change on nophen 500 mg one capsule				
	every six hours as ne					
	as administered at 8:0					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		hal041062	B. WING		03/2	26/2018	
	ROVIDER OR SUPPLIER ALE LAWNDALE PARK	4400 LAWI	DRESS, CITY, STA NDALE DRIVE ORO, NC 2745				
(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 358	Continued From page	25	D 358				
	-She read the eMAR removed the medicatir-She read the labels of placed the medication administration to the result of the medication administration to the result of the medications as written. She made sure she as medications as written. Refer to interview with nurse (HWN) on 03/2. Refer to interview with (ED) on 03/22/18 at 5. Refer to interview with Care Provider on 03/2. Refer to telephone into contracted pharmacy at 11:45 am. Refer to interview with 3:50 pm. Refer to interview with Director on 03/23/18 at 5. C. Observation of the at 7:50 am revealed: -Colchicine 0.6 mg or	ne facility for 19 years. for each resident before she ions from the cart. for each medication as she in the medicine cup for resident. administered the in on the eMAR. In the Health and Wellness 12/18 at 4:05 pm. In the Executive Director 13:30 pm. In Resident #3's Primary 123/18 at 11:15 am. Iterview with the facility's Irepresentative on 03/23/18 at In the Associate Executive at 4:25 pm. In the tablet was administered 10 a.m by a medication aide In the hallway at the In the hallway at the In the Associate Execution aide In the hallway at the					

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package read, "colchicine 0.6 mg tablet take one

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	D
		hal041062	B. WING		03/26/2	2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		4400 LAWI	NDALE DRIVE			
BROOKD	ALE LAWNDALE PARK	GREENSB	ORO, NC 274	55		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		DATE
D 358	Continued From page	e 26	D 358			
	tablet twice a day as	needed for gout."				
		3's signed physician's				
		3 revealed there was an				
	order for colchicine 0.	.6 mg every 48 nours.				
	Review of Resident #					
	02/20/18 revealed the					
	• .	ed to treat gout) twice a day				
	hours was not on the	Colchicine 0.6 mg every 48 FL2.				
	Review of Resident # revealed:	3's March 2018 eMAR				
		or colchicine 0.6 mg every				
	48 hours. There was administration.					
		reflect the order change on				
	be discontinued.	e 0.6 mg every 48 hours to				
		blet was documented as				
	administered at 8:00	am on 3/22/18.				
	Interview on 3/22/18 a revealed:	at 8:00 am with a MA				
		ne facility for 19 years.				
		for each resident before she				
	removed the medicati					
		for each medication as she				
	administration to the	n in the medicine cup for				
	-She made sure she					
	medications as written					
	Refer to interview with	h the Health and Wellness				
	nurse (HWN) on 03/2	2/18 at 4:05 pm.				
	Refer to interview with (ED) on 03/22/18 at 5	h the Executive Director 5:30 pm.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
		hal041062	B. WING		03	/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STATE	, ZIP CODE		
BROOKD	ALE LAWNDALE PARK		NNDALE DRIVE BORO, NC 27455			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETE DATE
D 358	Continued From page	e 27	D 358			
	Refer to interview with Care Provider on 03/2	h Resident #3's Primary 23/18 at 11:15 am.				
		terview with the facility's representative on 03/23/18				
	Refer to interview with 3:50 pm.	h Resident #3 on 03/23/18 at				
	Refer to interview with Director on 03/23/18	h the Associate Executive at 4:25 pm.				
	(HWN) on 03/22/18 a -The HWN and the cl completed random el -The new eMARs we eMARs each month; the HWN and the clin	inical support staff MAR audits. re compared to the old this was the responsibility of				
	03/22/18 at 5:30 pm r -The HWN and the cl completed random et -The new eMARs wer eMARs each month; the HWN and the clin -There was nothing in audit process.	inical support staff MAR audits. re compared to the old this was the responsibility of				
	-The provider did not not being followed.	nt #3's Primary Care at 11:15 am revealed: know the FL2 orders were				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMP	LEIED
		hal041062	B. WING		03	/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE LAWNDALE PARK	4400 LAW	NDALE DRIVE			
	TEE EATHOREE FAIR	GREENSE	BORO, NC 2745	55		
(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 ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	28	D 358			
	administer medication	ns as ordered				
		were current and correct.				
	pharmacy representarevealed: -The pharmacy did not eMARs for the facility -The pharmacy did not the facilityThe pharmacy filled is would send the medicular and the medicular and the facility had faxed 02/20/18The contracted pharmacy filled is a changedThey would make chorders immediately.	ot enter or change orders for medication orders and cation to the facility. It down the FL2 dated				
	pm revealed: -The staff administere	ed all medications.				
		know of all the medications				
	O3/23/18 at 4:25 pm r -She started working -The contracted pharm into the facility's eMAI -She was unsure if the eMARs or if the contra eMARsTo her knowledge the able to look at the ord -The facility nurse and completed random eMi	at the facility 03/12/18. macy did not enter orders R system. e facility printed off the acted pharmacy printed the e contracted pharmacy was lers in the eMAR system. d the clinical support staff				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		hal041062	B. WING		03/2	26/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
BROOKD	ALE LAWNDALE PARK		NDALE DRIVE				
	T		ORO, NC 2745				
(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 358	0 358 Continued From page 29		D 358				
	the nurse and the clin						
	administered as order orders for insulin; whi blood sugar levels, a symptoms of dehydra altered kidney functio cause tachycardia, he headaches, a vasodil rapid decrease in bloom an analgesic; which cand an anti-inflammal nausea, vomiting and extended use if not acfailure to assure medias ordered by the lice practitioner was detrii	ator; which can cause a od pressure and heart rate, an cause increased pain, tory; which can cause abdominal pain from dministered as ordered. The ications were administered					
	on 03/23/18 as follow -The facility will imme orders on the eMARThe facility will scheo all MA's on completio order tracking form, a -The Health and Well Resident Care Coord Resident Care Aide w tracking form as orde and verificationThe HWD, RCC, or I conduct monthly eMA	diately update physicians dule mandatory retraining for n and verification of the new s well as, FL2 compliance. ness Director (HWD), inator (RCC), and/or vill audit the new order rs are received for accuracy ead Resident Care Aide will are audits.					

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED	
		hal041062	B. WING		03/26	3/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
		4400 LAW	NDALE DRIVE				
BROOKD	ALE LAWNDALE PARK	GREENSB	ORO, NC 2745	55			
(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	(X5) COMPLETE DATE	
D 358	Continued From page	e 30	D 358				
	2018 .						
D 463	10A NCAC 13F .1306 Care Unit	S Admission To The Special	D 463				
	Care Unit In addition to meeting in the rules of this Sul of residents to the hor that the following requ admission to the spec (1) A physician shall resident's FL-2 that m specific group of resid (2) There shall be a c screening by the facili appropriateness of an the special care unit. (3) Family members resident to a special of disclosure information and any additional wr policies and procedur this Subchapter that is	cial care unit: specify a diagnosis on the neets the conditions of the dents to be served. documented pre-admission ity to evaluate the n individual's placement in seeking admission of a care unit shall be provided in required in G.S. 131D-8 itten information addressing res listed in Rule .1305 of					
	facility failed to assure completed for 1 of 2 s	as evidenced by: and record reviews, the e disclosure information was sampled residents (Resident pecial Care Unit (SCU).					
	The findings are:						
		1's current FL2 dated 4/8/17 ncluded vascular dementia, nxiety.					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	PLETED
		hal041062	B. WING		03.	/26/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	JE ZIP CODE		
TO THE OTHER	NOVIDEN ON OUT FEEL		NDALE DRIVE			
BROOKD	ALE LAWNDALE PARK		ORO, NC 274	55		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 463	Continued From page	e 31	D 463			
	revealed an admissio	nt Register for Resident #1 n date of 8/3/15 to the SCU.				
	Interview with the Res (RCC) on 3/23/18 at 4 -She assisted the Hea (HWD) with admitting -She assisted with thi	sident Care Coordinator 4:05 pm revealed: alth and Wellness Director new residents.				
	(HWD) on 3/23/18 at -She and the RCC we new residentsEach admission pack information sheetOnce signed, a copy	ket contained a disclosure of the disclosure s placed in the resident's				
	3/23/18 at 4:15 pm re -She began working a - She did not know wh the disclosure information-All files and records to	sociate Executive Director on evealed: at the facility 1 week ago. by the facility did not have ation sheet for Resident #1. for Resident #1 had been osure information sheet was				
	3/26/18 at 12:00 pm r -She did not recall red					

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 463 Continued From page 32 -A medicare/medicaid program had been responsible for setting up the admission for the resident. -She knew the resident was admitted to a locked SCU. -She would sign the disclosure information sheet so it would be in the resident's record. Interview with the Resident Care Coordinator (RCC) on 3/23/18 at 4:05 pm revealed: -She assisted the Health and Wellness Director (HWD) with admitting new residents. -She was unaware the disclosure was not completed. Interview with the Health and Wellness Director (HWD) on 3/23/18 at 4:05 pm revealed: -She and the RCC were responsible for admitting new residents. -Each admission packet contained a disclosure information sheet. -Once signed, a copy of the disclosure information sheet was placed in the resident's	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
CALL DATE			hal041062	B. WING		03	3/26/2018
CALL DESCRIPTION SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (AS)	NAME OF P	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	BROOKD	ALE LAWNDALE PARK					
-A medicare/medicaid program had been responsible for setting up the admission for the residentShe knew the resident was admitted to a locked SCUShe would sign the disclosure information sheet so it would be in the resident's record. Interview with the Resident Care Coordinator (RCC) on 3/23/18 at 4:05 pm revealed: -She assisted the Health and Wellness Director (HWD) with admitting new residentsShe assisted with thinning the recordsShe was unaware the disclosure was not completed. Interview with the Health and Wellness Director (HWD) on 3/23/18 at 4:05 pm revealed: -She and the RCC were responsible for admitting new residentsEach admission packet contained a disclosure information sheetOnce signed, a copy of the disclosure information sheet was placed in the resident's	PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	COMPLETE
-She was unable to locate Resident #1's disclosure information sheet. Interview with the Associate Executive Director on 3/23/18 at 4:15 pm revealed: -She had only begun working at the facility 1 week ago She did not know why the facility did not have the disclosure information sheet for Resident #1All files and records for Resident #1 had been checked and no disclosure information sheet was located. Interview with Resident #1's contact person on 3/26/18 at 12:00 pm revealed:	D 463	-A medicare/medicai responsible for settin residentShe knew the reside SCUShe would sign the so it would be in the Interview with the Re (RCC) on 3/23/18 at -She assisted the He (HWD) with admitting -She assisted with th -She was unaware the completed. Interview with the He (HWD) on 3/23/18 at -She and the RCC with mew residentsEach admission pact information sheetOnce signed, a copy information sheet was recordShe was unable to ledisclosure information interview with the As 3/23/18 at 4:15 pm residentsShe had only begun week ago She did not know with the disclosure information checked and no disclosated. Interview with Reside interview with Reside interview with Reside checked.	d program had been g up the admission for the ent was admitted to a locked disclosure information sheet resident's record. esident Care Coordinator 4:05 pm revealed: ealth and Wellness Director g new residents. inning the records. he disclosure was not ealth and Wellness Director 4:05 pm revealed: ere responsible for admitting exet contained a disclosure of the disclosure graph of the disclosure splaced in the resident's exet contained a disclosure of the disclosure splaced in the resident's exet Resident #1's n sheet. Sociate Executive Director on exercise the facility of the disclosure for Resident #1. For Resident #1 had been losure information sheet was ent #1's contact person on	D 463			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			SURVEY PLETED	
		hal041062	B. WING		03	/26/2018
	ROVIDER OR SUPPLIER ALE LAWNDALE PARK	4400 LA	ADDRESS, CITY, STATE WNDALE DRIVE BBORO, NC 27455	, ZIP CODE		
(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 ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 463	-A medicare/medicaid responsible for setting residentShe knew the reside SCU.	ceiving or signing a n sheet for Resident #1. If program had been g up the admission for the nt was admitted to a locked	D 463			
D912	G.S. 131D-21 Declar Every resident shall h 2. To receive care ar adequate, appropriate	laration of Residents' Rights ration of Residents' Rights have the following rights: and services which are e, and in compliance with estate laws and rules and	D912			
	review, the facility fail received care and ser appropriate, and in co federal and state laws	as evidenced by: n, interview and record ed to assure each resident rvices which were adequate, compliance with relevant and rules and regulations ion administration and health				
	The findings are:					
	interviews, the facility notification for 1 of 5 : #3) regarding blood p failed to schedule app International Normaliz	ions, record reviews and failed to ensure physician sampled residents (Resident pressure (BP) results and pointments to have ged Ratio (INR) levels				

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		hal041062	B. WING		03/	26/2018
	ROVIDER OR SUPPLIER ALE LAWNDALE PARK	4400 LAW	ORESS, CITY, STANDALE DRIVE			
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D912	.0902(b) Health Care 2. Based on observat reviews, the facility fa were administered as prescribing practitione residents (Resident # diuretic, a beta blocket	ions, interviews, and record iled to assure medications ordered by the licensed er for 1 of 5 sampled (3) with orders for insulin, a er, a vasodilator, an i-inflammatory. [Refer to Tag 5.1004(a) Medication	D912			

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