	HAL013019	B. WING		12/(01/2022
OVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE		
LE CONCORD PARKWA	Y		CH ROAD NW		
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Cabarrus County Dep conducted an annual	artment of Social Services and follow-up survey on	D 000	for Brookdale Concord regarding the Statemer Deficiencies dated 12/1 of Correction is not to b an admission of or agre		
 10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: 		D 235	Statement of Deficienci related sanction or fine submitted as confirmati ongoing efforts to comp statutory and regulatory requirements. In this d have outlined specific a response to identified is have not provided a de to each allegation or fin we identified mitigating remain committed to th quality health care serv continue to make change	clusions in the ficiencies, or any or fine. Rather, it is a firmation of our o comply with ulatory this document, we ecific actions in tified issues. We d a detailed response n or finding, nor have gating factors. We d to the delivery of re services and will e changes and	
This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure an annual FL2 was completed for 2 of 5 sampled residents (#3 and #1).					
 Review of Resident #3's current FL2 dated 08/04/21 revealed: Diagnoses included dementia. Resident #3 required total care assistance for bathing and dressing. Documented level of orientation was intermittently disoriented. 					
	LE CONCORD PARKWA SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Initial Comments The Adult Care Licens Cabarrus County Dep conducted an annual November 29, 2022 th 10A NCAC 13F .0703 Medical Examination / 10A NCAC 13F .0703 Examination And Imm (b) Each resident sha examination prior to a annually thereafter. (c) The results of the required in Paragraph entered on the FL-2, N Program Long Term C North Carolina Medica Retardation Services, following: This Rule is not met a Based on record revise facility failed to ensure completed for 2 of 5 s #1). The findings are: 1. Review of Resident 08/04/21 revealed: -Diagnoses included of resident #3 required bathing and dressing. -Documented level of	DVIDER OR SUPPLIER STREET / LE CONCORD PARKWAY 2452 RC CONCO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments Initial Comments The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted an annual and follow-up survey on November 29, 2022 through December 1, 2022. 10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure an annual FL2 was completed for 2 of 5 sampled residents (#3 and #1). The findings are: 1. Review of Resident #3's current FL2 dated 08/04/21 revealed: Diagnoses included dementia. -Resident #3 required total care assistance for bathing and dressing. -Documented level of orientation was intermittently disoriented.	ONDER OR SUPPLIER STREET ADDRESS, CITY, ST LE CONCORD PARKWAY 2452 ROCK HILL CHURK CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Initial Comments D The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted an annual and follow-up survey on November 29, 2022 through December 1, 2022. D 10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im D 235 10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im D 235 (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. D 235 (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure an annual FL2 was completed for 2 of 5 sampled residents (#3 and #1). The findings are: 1. Review of Resident #3's current FL2 dated 08/04/21 revealed: -Diagnoses included dementia. -Resident #3 required total care assistance for bathing and dressing. -Documented level of orientation was intermittently disoriented. Doutented level of orientation was intermittently disoriented.	Divider OR SupPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2452 ROCK HILL CHURCH ROAD NW CONCORD, NC 28027 2452 ROCK HILL CHURCH ROAD NW CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WISE BE PRECEDED BUT FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D D PREVIDER'S PLAN OF (EACH ORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCY TAG Initial Comments D 000 The following is the Pla for Brookdale Concord regarding the Statement Deficiencies dated 12/1 of Correction is not to E cabarus County Department of Social Services conducted an annual and follow-up survey on November 29, 2022 through December 1, 2022. D 235 D 2455 10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im submitted as confirmation required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: D 235 D 245 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure an annual FL2 was completed for 2 of 5 sampled residents (#3 and #1). The findings are: 1. Review of Resident #3's current FL2 dated 80/04/21 revealed: -Diagnoses included dementia. -Resident #3 required total care assistance for bathing and dressing. -Documented Level of orientation was intermittently disoriented. Hist of interviews intermined.	Divide on supplier STREET ADDRESS, GTV, STATE, 2P CODE 2452 ROCK HILL CHURCH ROAD NW CONCORD, NC 28027 2452 ROCK HILL CHURCH ROAD NW CONCORD, NC 28027 Summary STATEMENT OF DEFIDENCES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PD PRETAX TAG Dial PROVIDER'S FLAW OF CORRECTION (EACH ORRECTIVE ACTION SHOLD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) Initial Comments D 000 The Adult Care Licensure Section and the Cabarus County Department of Social Services conducted an annual and follow-up survey on November 29, 2022 through December 1, 2022. The following is the Plan of Correction for Brookdale Concord Parkway regarding the Statement of Deficiencies dated 12/1/122. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as colinos in the statutory and regulatory requirements. In this document, we have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of Program Long Term Care Services, or MR-2. North Carolina Medicaid Program Long Term Care Services, or MR-2. North Carolina M

Reviewed and acknowledged by Melissa J. Jones, SW on 01-30-23.

TATEMENT OF D ND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
HAL013019		HAL013019	B. WING		12/	01/2022
AME OF PROVID	ER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ROOKDALE	CONCORD PARKW	AY	CK HILL CHUR RD, NC 28027			
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
Rev reve Rev was the Ref 12/0 2. F 11/3 frac loss urin Rev reve -Init -Th corr -Cu Ref 12/0 Ref 12/0 Ref 12/0 Rev reve -Init -Th corr -Cu Ref 12/0 Ref 12/0 Rev reve -Init -Th corr -Cu Ref 12/0 Rev reve -Init -Th corr -Cu Ref 12/0 Rev Rev reve -Init -Th corr -Cu Rev Rev Rev Rev Rev Rev Rev Rev Rev Rev	ealed an admissio view of Resident # s not an updated F primary care prov er to interview with 01/22 at 11:47am. er to interview with 01/22 at 11:10am. Review of Residen 30/22 revealed dia eture of unspecifier s and benign prost ary tract symptom view of Resident # ealed an admissio view of Resident # ealed: tial FL2 was dated ere was no docum npleted annually. rrent FL2 was con er to interview with 01/22 at 11:47am. er to interview with 01/22 at 11:10am. rview with the Res 1:47am revealed:	3's Resident Register n date of 05/08/16. 3's record revealed there FL2 completed or signed by ider (PCP) after 08/04/21. In the Regional Director on the Administrator on t #1's current FL2 dated gnoses included unspecified d femur, unspecified hearing atic hyperplasia with lower is 1's Resident Register n date of 10/15/21. 1's record on 11/30/22 11/04/21. hentation that a FL2 was inpleted 11/30/22. In the Regional Director on in the Administrator on	D 235	DEFICIENCY) Rule .0703 Resident charts will be audited by the Health and W Director or Designee for com the documentation of tubercu testing. Updated testing will completed, as needed and p charts. Chart audits will be d quarterly by the Health and W Director or designee for com The Health and Wellness Dir designee will review the FL2 completeness prior to admiss including testing for tuberculo testing. The Assisted Living I designee will review new adr charts for FL2 completion an quarterly by the Health and W Director or designee for com	pletion of losis be laced in lone Vellness pliance. rector or for sion, osis Director or mission d then Vellness	1/31/23

Division of Health Service Regulation STATE FORM

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Division	of	Health	Service	Regulation
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of Health Service Regu					
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 12/01/2022	
	HAL013019	B. WING			
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ITE, ZIP CODE		
	2452 RO	CK HILL CHURC	H ROAD NW		
ALE CONCORD PARKW	CONCOR	RD, NC 28027			
		BE	(X5) COMPLETE DATE		
Continued From page	2	D 235			
acquire the physician -The FL2 was to be c and annually after tha -Once the FL2 was co the tracker for audits. -The Administrator wa the tracker on a daily tasks. -There was a large ar and could account for completed yearly. Interview with the Adr 11:10am revealed: -The HWD was responded FL2 upon resident ad -The HWD was respondent Signature from the ph completion date into the -She was responsibled daily basis for completed tracker. -She did not check the the FL2s due to a hig 10A NCAC 13F .0801 (b) The facility shall are each resident is completed following admission are thereafter using an as- established by the Decent	 S signature. S signature. S signature. S ompleted before admission it. S presponsible for auditing basis for completion of the mount of turn over in staff T the FL2's not being Ministrator on 12/01/22 at S misible for completion of the mission and yearly. S misible for getting the ysician and entering the he tracker. F for auditing the tracker on a ation of the task in the E tracker for completion of he turn over rate in staff. (b) Resident Assessment of bleted within 30 days and at least annually ssessment instrument partment or an instrument 	D 254	designee will complete resident plans within 30 days following admission, every six months and the resident has a change in the condition. The Health and Welln Director or designee will place d dates on the chart audit tool for tracking. The Health and Wellne Director or designee will review chart audit tool on a weekly basi	care d if eir less lue ess the is for	1/31/23
containing at least the required on the estab assessment to be cor following admission a	e same information as lished instrument. The npleted within 30 days nd annually thereafter shall				
	OF DEFICIENCIES OF CORRECTION ROVIDER OR SUPPLIER ALE CONCORD PARKW/ SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR I Continued From page acquire the physician -The FL2 was to be c and annually after tha -Once the FL2 was to be c and annually after tha -Once the FL2 was co the tracker for audits. -The Administrator wa the tracker on a daily tasks. -There was a large ar and could account for completed yearly. Interview with the Adr 11:10am revealed: -The HWD was respon signature from the ph completion date into t -She was responsible daily basis for complet tracker. -She did not check that the FL2s due to a hig 10A NCAC 13F .0801 (b) The facility shall a each resident is comp following admission a thereafter using an as established by the Dep containing at least the required on the estab assessment to be cor following admission a	OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013019 HAL013019 ROVIDER OR SUPPLIER STREET AT 2452 ROU CONCOR ALE CONCORD PARKWAY 2452 ROU CONCOF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 acquire the physician's signature. -The FL2 was to be completed before admission and annually after that. -Once the FL2 was completed, it was logged into the tracker for audits. -The Administrator was responsible for auditing the tracker on a daily basis for completion of the tasks. -There was a large amount of turn over in staff and could account for the FL2's not being completed yearly. Interview with the Administrator on 12/01/22 at 11:10am revealed: -The HWD was responsible for completion of the FL2 upon resident admission and yearly. -The HWD was responsible for getting the signature from the physician and entering the completion date into the tracker. -She was responsible for auditing the tracker on a daily basis for completion of the task in the	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE IDEMTIFICATION NUMBER: A. BUILDING: IDEMTIFICATION NUMBER: B. WING IDEMTIFICATION NUMBER: B. WING ALE CONCORD PARKWAY 2452 ROCK HILL CHURC CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 2 D 235 acquire the physician's signature. - -The FL2 was to be completed before admission and annually after that. - -Once the FL2 was completed, it was logged into the tracker on a daily basis for completion of the tasks. - -The Administrator was responsible for auditing the tracker on a daily basis for completion of the FL2 upon resident admission and yearly. - -The HWD was responsible for completion of the FL2 upon resident admission and entering the completion date into the tracker. - -She was responsible for auditing the tracker on a daily basis for completion of the task in the tracker. - -She did not check the tracker for completion of the FL2 so and the tracker. - -She did not check the tracker for completion of the FL2 so and high turn over rate in staff. - 10A NCAC 13F .0801(b) Resident Assessment of each resident is completed within 30 days following admission and at least a	OPEDEFICIENCIES P(1) PROVIDERSUPPLIERULIA IDENTFICATION NUMBER: HALDI3019 P(2) MULTIPE CONSTRUCTION A. BUILDING. HALDI3019 OV/DER OR SUPPLIER STREET ADDRESS, CTY, STRE, ZP CODE NUE CONCORD PARKWAY 2452 ROCK HILL CHURCH ROAD NW CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES RECOLOREDROK VISE PRECEDED BY PULL REGULATORY OR LSC IDENTFYING INFORMATION) D Continued From page 2 D acquire the physician's signature. -The FL2 was to be completed before admission and annually after that. -Once the FL2 was completed, it was logged into the tracker for audits. -The Kadministrator was responsible for auditing the tracker or audits. -The KAUM State or auditing the tracker or audits. -The HWD was responsible for completion of the tasks. Rule .0801 The Health and Wellness Direct designee will complete resident plans within 30 days following an the resident has a change in the condition. The Health and Wellness Direct dates on the chart audit tool for tracker. -She was responsible for completion of the tasks. 10A NCAC 13F .0801(b) Resident Assessment (b) The facility shall assure an assessment of each resident us assure an assessment of each resident us assure an assessment of each resident within 30 days following amission and at least the same information as required on the established instrument established by the Department tor an instrument approved by the Department tor an instrument approved by the Department tor an instrument assument to be completed within 30 days following amission and aulary thereafter shall D	OP DEPROSENCES [P1] PROVDERSUPPLIERCLA DEENTFICATION NUMBER: (P2) NULTHEL CONSTRUCTION A BUILDING: (P2) NULTHEL CONSTRUCTION A BUILDING: (P2) NUTHEL CONSTRUCTION A BUILDING: (P2) DATE SU COMPLE SOUDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2P CODE 12/01 ALE CONCORD PARKWAY 2452 ROCK HILL CHURCH RADA NW CONCORD, NC 28027 PROVIDERS PLAN OF CORRECTION (ECX) CORSTRUCTOR VISITE PRECEDED BY FULL REGULATORY OR LSC DENTFYING MFORMATION) PROVIDERS PLAN OF CORRECTION (ECX) CORSTRUCTOR OR SUPPLIER Continued From page 2 D 235 RCK HILL CHURCH RADA NW CONCORD, NC 28027 PROVIDERS PLAN OF CORRECTION (ECX) CORRECTION OF LAPPOORMATE DEFICIENCY) Continued From page 2 D 235 RCLE LABOR OF ADDITION (ECX) CORRECTION OF LAPPOORMATE DEFICIENCY) DEFICIENCY Continued From page 2 D 235 RUIE .0801 The HEAD ADDITION OF LAPPOORMATE DEFICIENCY) DEFICIENCY Continued From page 2 D 235 D 235 RUIE .0801 The HEAD ADDITION OF LAPPOORMATE DEFICIENCY) Continued From page 2 D 235 D 235 The Health and Wellness Director or designee will completer resident care plans within 30 days following admission, every six months and if the resident and wellness Director or designee will place due dates on the chart audit tool for completion date into the tracker. She was responsible for auditing the tracker on a daily basis for completion of the tasker. D 254 <t< td=""></t<>

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If continuation sheet 3 of 21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY
		HAL013019	B. WING		12	/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	ZIP CODE		
BROOKD	ALE CONCORD PARKW	2452 RC	CK HILL CHURCH	ROAD NW		
		CONCO	RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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) COMPLET DATE
D 254	Continued From page	e 3	D 254			
	2254 Continued From page 3 resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource.					
	failed to ensure 1 of 3 (Resident #1) was up	iew and interviews the facility 3 sampled residents				
	11/30/22 revealed: -An admission date of -Diagnoses included unspecified femur, un	#1's current FL2 dated of 11/19/21. unspecified fracture of nspecified hearing loss and erplasia with lower urinary				
vision of Ho	11/09/21 revealed: -Resident was indep -Resident required lin bathing, dressing, gra transferring.	#1's current care plan dated endent with eating. mited assistance with ooming, ambulation and tensive assistance with				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: HAL013019		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		HAL013019	B. WING		12	/01/2022
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
DOOKD		2452 RO	CK HILL CHURCH	ROAD NW		
RUOKDA	LE CONCORD PARKW	CONCO	RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 254	Continued From page	4	D 254			
	toileting.					
	revealed:	1's record on 11/30/22 Service Plan (PSP) was				
-There plan w Intervi Direct		tation the resident's care nnually.				
		Iministrator and Regional at 11:29am and 11:48am				
	care plans upon admi	as to complete resident ssion, every 6 months and if ange in their condition.				
		ness Coordinator (HWC) mplete resident care plans.				
		were to be signed by the				
	- +	an (PCP) within 15 days and a binder for the in-house				
	PCP, or sent out via faproviders.	ax or mail to outside				
	-The facility generated	d Personal Services Plans ne PCP's signed care plans				
	aides (PCPs) in a bine	ly available to personal care der kept in the medication				
room. -The PSPs in the binder in the medication room just print-puts and were not signed by the PCP. -The administrator and the Regional Director were not sure if the PSP binder was up to date for all residents. -The Health and Wellness Director (HWD) was to follow-up behind the HWC regarding completion	-The PSPs in the bind					
	were not sure if the Pa					
	of care plans.					
	filed in each residents					:
	-The HWD was respo plan audit tool daily.	nsible to check the care				

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If continuation sheet 5 of 21

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL013019	B. WING		12/0	1/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE		
BROOKD	ALE CONCORD PARKWA	AY	CK HILL CHURCH RD, NC 28027	H ROAD NW		
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 263	Continued From page	9 5	D 263	_ /		
D 263	10A NCAC 13F .0802	(e) Resident Care Plan	D 263	Rule .0802 The Health and Wellness D	irector	
	10A NCAC 13F .0802			or designee will complete re care plans within 30 days fo admission, every six monthe	sident Ilowing	1/31/23
		assure that the resident's personal care services and		with a resident change of	s,anu	
		by signing and dating the lendar days of completion		condition. The Health and W	++	
	of the assessment:			Director or designee will ser resident care plan to the res		
	(1) the resident is un and	der the physician's care;		physician to be signed and	dated	
		a medical diagnosis with		within 15 days of completion assessment.	n of the	
	associated physical or mental limitations that justify the personal care services specified in the care plan.			Once the care plans are sig the physician they will be file residents record and placed	ed in the	
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the residents' physician certified their care by signing and dating care plans within 15 days of assessment for 3 of 3 sampled residents (Residents #1, #4 and #5).			chart audit tool for tracking. Health and Wellness Director designee will review the cha tool on a weekly basis for compliance of resident care	The or or art audit	
	The findings are:					
	1. Review of Residen 12/27/21 revealed:	t #4's current FL2 dated				
	osteoarthritis and pso	dementia, hypertension, riasis. ermittently disoriented.				
		personal care assistance				
	Review of Residents a revealed an admission	#4's Resident Register n date of 02/25/17.				
	-Resident required se	4's Care Plan revealed: t-up assistance for laying plies and safety devices as				
) ivision of Hea	Ith Service Regulation		1			

Division of Health Service Regulation STATE FORM

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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	
		HAL013019	B. WING		/01/2022		
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE			
		2452 RO	CK HILL CHURCH	ROAD NW			
BROOKD	ALE CONCORD PARKWA	AY	RD, NC 28027				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE	
D 263	Continued From page	6	D 263				
	needed for showering	ı or bathing.					
	-The care plan was in	-					
		d Wellness Coordinator)					
		care plan on 11/30/22.					
	-	Primary Care Physician)					
		care plan on 11/30/22.					
	-The resident's care p	lan was not signed within					
	15 days of the assess	sment.					
		th the Administrator and					
		12/01/22 at 11:29am and					
	11:48am.						
		t #1's current FL2 dated					
	11/30/22 revealed:						
	-An admission date of						
	-	unspecified fracture of					
	-	specified hearing loss and					
	tract symptoms.	rplasia with lower urinary					
	Review of Resident #	1's care plan dated					
	11/09/2021 revealed:						
	-Resident was indepe	ndent with eating.					
	-Resident required lim	nited assistance with					
		oming, ambulation and					
	transferring.						
	-Resident required ex toileting.	tensive assistance with					
	Review of Resident #	1's record on 11/30/22					
	revealed:						
	-Initial Personal Servi	ce Plan was dated 11/30/21.					
	-The Personal Service	e Plan was not signed or					
		dar days of completion of					
	the assessment.						
	Refer to interviews wi	th the Administrator and					
	-	12/01/22 at 11:29am and					
	11:48am.						
	3. Review of Resident	t #5's current FL2 dated					

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If continuation sheet 7 of 21

f of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	HAL013019	B. WING		12	2/01/2022
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	2452 RO	CK HILL CHURCH	ROAD NW		
	CONCOR	RD, NC 28027			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
07/08/22 revealed: -Diagnoses included anxiety disorder, aner reflux disease (GERD depression, essential obstructive pulmonary -The resident was inco- bladder, semi-ambular needed personal care and dressing. Review of Residents revealed an admission Review of Resident # 06/21/22 revealed: -She required assistant dressing, grooming, p shoes, cleaning and so out of showering supprishampooing hair, batt toileting, and physicant dining room and othe -She required the uses sitter to prevent falls. -The care plan was deprinted on 11/29/22 arithe Health and Well signed and dated the -The resident's Prima- signed and dated the	orthostatic hypotension, mia, gastroesophageal)), muscle weakness, major hypertension, and chronic y disease (COPD). ontinent of bowel and tory with a wheelchair, and e assistance with bathing #4's Resident Register n date of 01/18/21. 5's Care Plan dated nce for cutting up food, butting on and taking off storing of vision aids, laying blies and safety devices, hing upper and lower body, assistance to and from the r common areas. e of a wheelchair and had a ated 06/21/22 and was t 3:23pm. ness Coordinator (HWC) care plan on 11/30/22. ry Care Provider (PCP) care plan on 11/30/22.	D 263			
-There were no other documented in the re- -There was a Persona to calculate monthly of	signed care plans cord. al Service Assessment (tool cost of care) completed upon				
	ROVIDER OR SUPPLIER ALE CONCORD PARKW/ SUMMARY ST. (EACH DEFICIENC' REGULATORY OR I Continued From page 07/08/22 revealed: -Diagnoses included anxiety disorder, aner reflux disease (GERE depression, essential obstructive pulmonary -The resident was inc bladder, semi-ambula needed personal care and dressing. Review of Residents revealed an admissio Review of Resident # 06/21/22 revealed: -She required assista dressing, grooming, p shoes, cleaning and s out of showering supp shampooing hair, batt toileting, and physical dining room and othe -She required the use sitter to prevent falls. -The care plan was da printed on 11/29/22 a -The Health and Well signed and dated the -The resident's Prima signed and dated the -There were no other documented in the re -There was a Persona to calculate monthly of admission on 06/21/22	DF CORRECTION IDENTIFICATION NUMBER: HAL013019 ALE CONCORD PARKWAY 2452 RO CONCOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 07/08/22 revealed: -Diagnoses included orthostatic hypotension, anxiety disorder, anemia, gastroesophageal reflux disease (GERD), muscle weakness, major depression, essential hypertension, and chronic obstructive pulmonary disease (COPD). -The resident was incontinent of bowel and bladder, semi-ambulatory with a wheelchair, and needed personal care assistance with bathing and dressing. Review of Residents #4's Resident Register revealed an admission date of 01/18/21. Review of Resident #5's Care Plan dated 06/21/22 revealed: -She required assistance for cutting up food, dressing, grooming, putting on and taking off shoes, cleaning and storing of vision aids, laying out of showering supplies and safety devices, shampooing hair, bathing upper and lower body, toileting, and physical assistance to and from the dining room and other common areas. -She required the use of a wheelchair and had a sitter to prevent falls. -The care plan was dated 06/21/22 and was printed on 11/29/22 at 3:23pm. -The Health and Wellness Coordinator (HWC) signed and dated the care plan on 11/30/22. Review of Resident #5's record revealed: -Ther were no other signed care plans documented in the record. -The resident #5's record revealed: -The resident	DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: HAL013019 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ALE CONCORD PARKWAY 2452 ROCK HILL CHURCH CONCORD, NC 28027 Image: Continued Prom page 7 D 263 07/08/22 revealed: D 263 -Diagnoses included orthostatic hypotension, anxiety disorder, anemia, gastroesophageal reflux disease (GERD), muscle weakness, major depression, essential hypertension, and chronic obstructive pulmonary disease (COPD). -The resident was incontinent of bowel and bladder, semi-ambulatory with a wheelchair, and needed personal care assistance with bathing and dressing. Review of Residents #4's Resident Register revealed an admission date of 01/18/21. Review of Resident #5's Care Plan dated 06/21/22 revealed: -She required assistance for cutting up food, dressing, grooming, putting on and taking off shoes, cleaning and storing of vision aids, laying out of showering supplies and safety devices, shampooing hair, bathing upper and lower body, toileting, and physical assistance to and from the dining room and other common areas. -She required the use of a wheelchair and had a sitter to prevent falls. -The care plan was dated 06/21/22 and was printed on 11/29/22 at 3:23pm. -The Health and Wellness Coordinator (HWC) signed and dated the care plan on 11/30/22. Review of Resident #5's record revealed: -There was a Personal Service Assessment (tool to calculate monthly cost of care) completed upon admission on 06/21/22 and previously on	JF CORRECTION IDENTIFICATION NUMBER: A BUILDING: HAL013019 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALE CONCORD PARKWAY 2452 ROCK HILL CHURCH ROAD NW CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREENT REGULATORY OR LSC IDENTIFYING INFORMATION) D PREENT TAG PROVIDER'S PLAN OF (EACH OCRRECTIVE ACT CROSS-REFERENCED TO DEFICIENCY Continued From page 7 D D 263 D 07/08/22 revealed: -Diagnoses included orthostatic hypotension, anxiety disorder, anemia, gastroesophageal reflux disease (GERD), muscle weakness, major depression, essential hypertension, and chronic obstructive pulmonary disease (CDPD). -The resident was incontinent of bowel and bladder, semi-ambulatory with a wheelchair, and needed personal care assistance with bathing and dressing. Review of Residents #4's Resident Register revealed an admission date of 01/18/21. Review of Residents #4's Resident Register revealed: -She required assistance for cutting up food, dressing, grooming, putting on and taking off shoes, cleaning and storing of vision aids, laying out of showering supplies and safety devices, shampooing hair, bathing upper and lower body, tolleting, and physical assistance to and from the dining room and other common areas. -She required the use of a wheelchair and had a sitter to prevent falls. -The readent #5's record revealed: -There ween o dher care plan on 11/30/22. -The resident #5's record revealed: -There ween no noter signed care plans documented in the record. -There was a Per	JF CORRECTION IDENTIFICATION NUMBER: A BUILDNO; 12 NUMCER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 12 RECONCORD PARKWAY 2452 ROCK HILL CHURCH ROAD NW CONCORD, AC 2027 RECAL DEFICIENCY MUST BE PRECEDED BY FULL PREVIDENCE (CORRECTIVE ACTION AND/LD BE CRUCKED THE ADDRESS, CITY, STATE, ZP CODE 10 RECAL DEFICIENCY MUST BE PRECEDED BY FULL PREVIDENCE (CORRECTIVE ACTION AND/LD BE CRUCKED) 10 RECAL DEFICIENCY ON LSC IDENTIFIVING INFORMATION) D PREVIDENCE (CORRECTIVE ACTION AND/LD BE CRUCKED TO THE APPROVMENTE DEFICIENCY) Continued From page 7 D 263 D7/08/22 revealed: D -The resident devide dorthosatic hypotension, anxiety discarder, anemia, gastroesophageal reflux disease (CORD). The resident devide dorthosatic hypotension, anxiety discarder, and chronic obstructive pulmonary disease (COPD). The resident thypertension, and chronic obstructive pulmonary disease (COPD). -The resident #5'S Care Plan dated 002/11/22 revealed: -She required assistance for cutting up food, dressing, grooming, putting on and taking off shower ing supplies and safety devices, sharpoolen have, basident #5'S Care Plan dated 002/11/22 revealed: -She required assistance to and from the dining room and disting of this not induced provider (PCP) signed and dated the care plan on 11/30/22. -She required massident dof/21/22 and was printed on 11/29/22 at 3:23pm. -The rewere no othere signed care plans on 03/20/22.

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E SURVEY IPLETED	
		HAL013019	B. WING	1	12/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BROOKD/		AY	CK HILL CHUR	CH ROAD NW		
		CONCOL	RD, NC 28027	· · · · · · · · · · · · · · · · · · ·		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 263	Continued From page	e 8	D 263			
	06/22/22 to evaluate services with diagnos pulmonary disease (C -There was a signed 06/26/22 with a diagn of the brain. -There was a signed 07/13/22 for oxygen a needed for shortness Refer to interviews with Regional Director on 11:48am.	and admit for Hospice es of chronic obstructive COPD) and failure to thrive. physician's order dated nosis of senile degeneration physician's order dated at 2 liters per minute as of breath. The Administrator and 12/01/22 at 11:29am and		Rule .0903 The Health and Wellness Director or Registered Nurse will review new		
	revealed: -The facility's policy w care plans upon admit there was a change of -The HWC was respondent care plans. -The Health and Well follow-up behind the l of care plans. -Once the care plans filed in each residents	ness Director (HWD) was to HWC regarding completion were signed they were to be		orders daily for any new LHPS task orders. Health and Wellness Director or Registered Nurse will complete the LHPSs and place on the chart audit tool for tracking. The HWD or designee will review the chart audit tool on a weekly basis. The Health and Wellness Director or designee will monitor the chart audit tool monthly for three months and then quarterly thereafter for compliance of LHPS.	1/31/2	
D 280	10A NCAC 13F .0903 Professional Support 10A NCAC 13F .0903 Professional Support (c) The facility shall a registered nurse, occu physical therapist in the	Elicensed Health Assure that participation by a Aupational therapist or	D 280			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			é Survey Pleted	
		HAL013019	B. WING				
IAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		12	2/01/2022	
		2452 RO	CK HILL CHURCH				
BROOKD	ALE CONCORD PARKW	/AY	RD, NC 28027				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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	(X5) COMPLE DATE	
D 280	Continued From pag	e 9	D 280				
	 (a) of this Rule, is codays of admission or a resident develops to least quarterly thereas following: (1) performing a phyresident as related to current condition requests specified in Pa (2) evaluating the rebeing provided; (3) recommending corresident as needed to assessment and evar resident; and 	ed, as required in Paragraph mpleted within the first 30 within 30 days from the date the need for the task and at after, and includes the visical assessment of the o the resident's diagnosis or uiring one or more of the ragraph (a) of this Rule; sident's progress to care thanges in the care of the based on the physical luation of the progress of the activities in Subparagraphs a Paragraph.					
	facility failed to ensur professional support completed for 3 of 5 #1, #4 and #5) with L ambulation and trans- removing thrombo-en (#4) and transfers, w oxygen as needed (# The findings are: 1. Review of Resider 11/30/22 revealed: -An admission date of	iews and interviews, the re quarterly licensed health (LHPS) assessments were sampled residents (Resident .HPS tasks for catheter care, sfers (#1), applying and mbolic deterrent (TED) hose ound care, and use of t5).					

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Division C	of Health Service Regu					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING:		COMPLE	ETED
				· · ·		
		HAL013019	B. WING		12/0	1/2022
		-	•			
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		2452 ROCI	K HILL CHURC	H ROAD NW		
BROOKD	ALE CONCORD PARKW	AY	, NC 28027			
			1 10 20021			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	GATE	DATE
		·····		DENOLUTY		
D 280	Continued From page	10	D 280			
5 - 44	Continued i form page		0 200			
	benian prostatic hype	rplasia with lower urinary				
	tract symptoms.					
	addroymptomo.					
	Deview of Devident #	dia aumanti LIDO data d				
		1's current LHPS dated	1			
		ks include positioning and	1			
		ry catheter bag and cleaning				
	around the urinary ca	theter, and ambulation using				
	assistive devices that	required physical				
J		erring semi-ambulatory or				
1	non-ambulatory resid	-				
	non-ambulatory resid	ents.				
1	Desidence of Desidence #	41				
		1's record on 11/30/22				
1	revealed:					
	 There was no docum 	nentation that a LHPS was				
]	completed within 30 c	lays of admission.				
		nentation that a LHPS was				
	completed quarterly.					
	-Current LHPS was c	omploted 11/20/22				
	-Current LHPS was c	ompieled 11/30/22.				
110						
1		h the Administrator on				
	11/30/22 at 10:19am.					
	Refer to interviews wi	ith the Administrator and				
		12/01/22 at 11:29am and				
	11:48am.	12/0 hze at 11.20am and				
	11.40am.					
		h the Regional Nurse on			1	
	12/01/22 at 2:24pm.					
	2. Review of Residen	t #4's current FL2 dated				
	12/27/21 revealed:				1	
		dementia, hypertension,			1	
	osteoarthritis and pso					
	-					
		ermittently disoriented.				
		personal care assistance				
	with bathing.					
i						
	Review of Resident #	4's Resident Register				
	revealed an admissio	÷				
	alth Service Regulation					
JIVISION OF Hes	ann Service Regulation					

Division of Health Service Regulation

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Division of	of Health Service Regu					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
			P MINC			
		HAL013019	B. WING		12	/01/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
RROOKR		2452 RC	CK HILL CHURCH	ROAD NW		
BROOKDI	ALE CONCORD PARKW/	CONCO	RD, NC 28027			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX	-	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE		COMPLETE DATE
TAG	REGULATORT OR I		TAG	DEFICIENCY)		
D 280	Continued From noor		D 280			
D 200	Continued From page		D 200			
		4's LHPS quarterly review				
		led tasks included TED				
	-	and removing them in the				
	evening along with m	÷				
		and skin breakdown or				
	redness.					
	Review of Resident #	4's LHPS quarterly review				
		led included TED hose.				
		de, transfers and PT/OT.				
	,					
	Review of Resident #	4's record on 11/30/22				
	revealed there no doo	cumentation of a LHPS				
	completed upon admi	ission and quarterly.				
	Refer to interview with 11/30/22 at 10:19am.	h the Administrator on				
	Thouse at to to dam.					
		ith the Administrator and				
	Regional Director on 11:48am.	12/01/22 at 11:29am and				
	Refer to interview with	h the Regional Nurse on				
	12/01/22 at 2:24pm.					
	·					
		t #5's current FL2 dated				
		agnoses included orthostatic				
	hypotension, anxiety					
	weakness, major dep	lux disease (GERD), muscle				
		ronic obstructive pulmonary				
	disease (COPD).	ionic obstructive putnonally				
	(
		#5's Resident Register				
	revealed an admissio	n date of 01/18/2021.				
	Deview of Destries 4.4					
	Review of Resident #					
	dated 08/26/21 revea	(LHPS) quarterly review				
		oulatory or non-ambulatory				
vision of Hay	alth Service Regulation	colocory of non-announcery				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CO		COM	E SURVEY PLETED
		HAL013019	B. WING		12	/01/2022
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE		
BROOKD	ALE CONCORD PARKW	AY	CK HILL CHURCH	ROAD NW		
	CHANNOV CT		RD, NC 28027			-
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
D 280	Continued From page	ə 12	D 280			
	residents.					
	Review of Resident #	5's record revealed:				
		physician's order dated				
		and admit for Hospice				
	thrive.	es of COPD and failure to				
		physician's order dated				
		osis of senile degeneration				
	of the brain.	where the second second second				
	-	physician's order dated at 2 liters per minute as				
	needed for shortness					
	-There were no other before or after 08/26/	LHPS reviews completed 21.				
	Review of Resident #	5's Licensed Health (LHPS) review dated				
		ks included transferring				
	semi-ambulatory or n	on-ambulatory residents,				
	oxygen administration ambulation using ass	n and monitoring, and istive devices.				
	at 2:55pm revealed th	gional Director on 11/30/22 here were no LHPS reviews int #5 between 08/26/21 and				
	Refer to interview wit 11/30/22 at 10:19am.	h the Administrator on				
		ith the Administrator and 12/01/22 at 11:29am and				
	Refer to interview wit 12/01/22 at 2:24pm.	h the Regional Nurse on				
		dministrator and Regional at 11:29am and 11:48am				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED	
		HAL013019	B. WING		12/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST/	ATE, ZIP CODE		
BROOKD	ALE CONCORD PARKW	AY	CK HILL CHURO RD, NC 28027			
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 280	reviews upon admissi were additional tasks -The Health and Welli responsible to comple -She or Regional Nur- completion of LHPS r compliance tracker. -The HWD was respo any changes with LHI Interview with the Reg 2:24pm revealed: -She was not aware t completed as required	vas to complete LHPS ion, quarterly, and if there added or removed. ness Director (HWD) was ete the LHPS reviews. se was to monitor eviews with the facility's unsible to notify care staff of PS tasks. gional Nurse on 12/01/22 at he LHPS were not being	D 280	Rule .1009		
D 406	10A NCAC 13F .1009 (b) The facility shall a needed in response to documented, includin appropriate health pro informed of the finding This Rule is not met Based on interviews a facility failed to ensure response to the quart of 5 sampled resident recommendations to a medication that could	gs when necessary. as evidenced by: and record reviews, the e action was taken in erly medication review for 2	D 406	The Health and Wellness Director of designee will review the quarterly pharmacy recommendations for order compliance. The order should then be placed in the primary care physician box for review and signed by the physician. The contracted pharmacy consultant will fax the medication review recommendation to the primary care physicians and the community upon completion of the quarterly reviews. The Health a Wellness Director or designee will review quarterly medication reviews and implement changes ordered by the primary care physician. The Health and Wellness Director or designee will monitor monthly for 3 months and then quarterly ongoing	1/31/2 I Is to nd	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		HAL013019	B. WING		12	12/01/2022	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DRESS, CITY, STATE	ZIP CODE			
		2452 RO	CK HILL CHURCH	ROAD NW			
SROOKD	ALE CONCORD PARKW	CONCOR	RD, NC 28027				
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 406	Continued From page	: 14	D 406				
	medication to treat ga disease (#5).	stroesophageal reflux					
	The findings are:						
	08/04/21 revealed:	t #3's current FL2 dated					
	-Diagnoses included						
	weakness, and athere -An order for aspirin 3						
	Review of Resident # reviews dated 06/17/2	3's quarterly medication					
	recommendation to de 325mg every day to 8	ecrease the aspirin from 1mg every day.					
	Review of Resident # 2022 electronic Media	3's October and November ation Administration					
		ealed an entry for aspirin					
	325mg every day doc 10/01/22 to 11/30/22.	umented as administered					
	Refer to interview with 11/30/22 at 11:31am	n the administrator on and 12/01/22 at 11:29am.					
		t #5's current FL2 dated					
		gnoses included orthostatic					
	hypotension, anxiety						
	gastroesophageal reti weakness, major dep	ux disease (GERD), muscle					
	÷ •	onic obstructive pulmonary					
	(<i>-</i> /-						
	Review of Resident #						
	• •	1 10/12/22 revealed an order					
	order date of 07/03/2	twice daily, with an original					
		#5's Resident Register					
	revealed an admission	n date of 01/18/2021.					

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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			SURVEY PLETED
		HAL013019	B. WING		12	/01/2022
NAME OF P	RÖVIDER ÖR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
		2452 RO	CK HILL CHURCH	ROAD NW		
BROOKD	ALE CONCORD PARKW	AY CONCO	RD, NC 28027			
(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) COMPLET DATE
D 406	Continued From page	e 15	D 406			
	Review of Resident # review dated 09/15/2 recommendation to d 20mg once daily inste 20mg twice daily. Review of Resident # and November 2022 Administration Recor- entry for omeprazole documented as admi 11/29/22. Refer to interview witt 11/30/22 at 11:31am Interview with the Add 11:31am and 12/01/2 -She was not sure if t review recommendat facility's contracted p -The quarterly pharm placed in the PCP's to and signed each wee -The facility's contract faxed the medication each residents' PCP completion of the qua -Resident's with prima the facility should rec directly from the phar -The Health and Well responsible to follow-	5's quarterly medication 2 revealed a lecrease omeprazole to ead of the current dose of 5's September, October, electronic Medication ds (eMARs) revealed an 20mg twice daily, nistered from 09/01/22 to h the Administrator on and 12/01/22 at 11:29am. 				

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<u>Division c</u>	of Health Service Regu	lation				
1	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (COMPL	
		HAL013019	B. WING		12/01/2022	
NAME OF PI	RÖVIDER ÖR SUPPLIER	STREET	ADDRESS, CITY, STATI	E, ZIP CODE		
BROOKD	ALE CONCORD PARKW	AY	OCK HILL CHURCH RD, NC 28027	ROAD NW		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X5) COMPLETE DATE
D 459	Continued From page	e 16	D 459			
D 459	10A NCAC 13F .1302	2 Special Care Unit	D 459			
	Disclosure 10A NCAC 13F .1302 Disclosure (a) Only those facilitie requirements of this S market or otherwise p providing special care Alzheimer's Disease of (b) The facility shall of the special care unit a and which addresses listed in Rule .1305 of This Rule is not met Based on record revie facility failed to disclosure treatment provided for care unit (SCU) for 2 and #3). The findings are: 1. Review of Resident # revealed an admission SCU. Review of Resident # revealed there was no disclosure statement.	2 Special Care Unit es with units that meet the Section may advertise, promote themselves as a units for persons with or related disorders. disclose information about according to G.S. 131D-8 policies and procedures if this Section as evidenced by: ew and interviews, the se the form of care and r residents in the special of 2 sampled residents (#2 t #2's current FL2 dated agnoses included dementia. 2's Resident Register n date of 02/06/20 to the 2's record on 11/29/22 o Special Care Unit (SCU)		Rule .1302 The Executive Director or designee will provide the S Care Unit Disclosure form admission and will review of completion. The Executive Director or designee will re- resident records of Memorr residents for completion of signature of Special Care ID Disclosure form. Executive Director or designee will m Memory Care resident reco- weekly and ongoing for compliance.	upon for eview y Care Unit ennitor	12/31/22
Division of Hea		/29/22 at 3:00pm was				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SU COMPLE	
		HAL013019	B. WING		12/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
PROOKD	ALE CONCORD PARKW	2452 RC	CK HILL CHURCH	ROAD NW		
BROORD		CONCO	RD, NC 28027			
(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	(X5) COMPLETE DATE
D 459	Continued From page	9 17	D 459			
	Refer to interview with 12/01/22 at 11:47am.	h the Regional Director on				
	Refer to interview with 12/01/22 at 11:10am.	h the Administrator on				
		t #3's current FL2 dated gnoses included dementia.				
		3's Resident Register n date of 05/08/16 to the				
		3's record on 11/29/22 o SCU disclosure statement.				
	Attempted interview v unsuccessful.	vith Resident #3's POA was				
	Refer to interview with 12/01/22 at 11:47am.	n the Regional Director on				
	Refer to interview with 12/01/22 at 11:10am.	n the Administrator on				
	at 11:47am revealed:					
	admission as part of t	nd marketing director upon he move in packet.				
		as responsible for nission packet and to make atement was in the resident				
	record.					
	Interview with the Adr 11:10am revealed:	ninistrator on 12/01/22 at				
	-The SCU disclosure					
	completed by sales a alth Service Regulation	nd marketing director upon				

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Division of Health Service Regul STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
	HAL013019				12/0	1/2022
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
BROOKD		AY	CK HILL CHURCH RD, NC 28027	H ROAD NW		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 459	admission who was no disclosure statement in packet. -She was responsible admission packet and	esponsible for getting the signed as part of the move for completion of the t to make sure the	D 459			
D 464	admission packet and to make sure the disclosure statement was in the resident record. 10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 2 of 2 sampled residents (#2 and #3) had an initial Special Care Unit (SCU) resident profile updated on a quarterly basis (#2 and #3).		D 464	Rule .1307 The Health and Wellness Director or designee will complete a chart audit of residents profile and care plans and updated on the chart audit tracking tool. The Health and Wellness Director or designee will be responsible for updating the assessment and serviced plan on admission, quarterly and with significant change in condition. The Health and Wellness Director or designee will review the chart audit tracking tool weekly for 3 months then review quarterly for compliance with resident profile and care plan.		1/31/23

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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	
		HAL013019	8. WING	8, WING		12/01/2022	
NAME OF PI	RÖVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
BROOKD	ALE CONCORD PARKW	ΔY	OCK HILL CHURCH ORD, NC 28027	ROAD NW			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)				(X5) COMPLET DATE	
D 464	Continued From page	e 19	D 464				
	The findings are:						
	08/03/22 revealed: -Diagnoses included	l total care assistance for , orientation was					
	Review of Resident # revealed an admissio	2's Resident Register n date of 02/06/20.					
		2's record on 11/29/22 are Unit (SCU) resident 2.					
	Refer to interview with 12/01/22 at 11:47am.	h the Regional Director on					
	Refer to interview witl 12/01/22 at 11:10am.	h the Administrator on					
	2. Review of Residen 0804/21 revealed: -Diagnoses included	t #3's current FL2 dated dementia.					
		total care assistance for orientation was					
	Review of Resident # revealed an admissio	3's Resident Register n date of 05/08/16.					
		3's record on 11/29/22 ent profile dated 08/03/22.					
	Refer to interview with 12/01/22 at 11:47am.	n the Regional Director on					

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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	
		HAL013019	B. WING		12	12/01/2022	
AME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE			
POOKD	LE CONCORD PARKWA	2452 RO	CK HILL CHURCH	ROAD NW			
		CONCOR	RD, NC 28027			-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			(X5) COMPLETI DATE		
D 464	Continued From page 20		D 464				
	Refer to interview with the Administrator on 12/01/22 at 11:10am.						
	Interview with the Reg at 11:47am revealed:	jional Director on 12/01/22					
	-The resident profile was to be completed by the Special Care Unit Coordinator (SCC) upon admission.						
	-The resident profile was to be updated on a quarterly basis.						
	-The SCC was responsible for completing the resident tracker once the resident profile and quarterly report was completed.						
		d the Health and Wellness					
	resident tracker on a completion of the resi	quarterly basis for					
	quarterly review. -She was not aware the resident profiles a	ne SCC had not completed nd quarterly reviews.					
	Interview with the Adn 11:10am revealed:	ninistrator on 12/01/22 at					
	SCC upon admission.						
	quarterly basis.	vas to be updated on a ofile and quarterly reports					
	were completed, the s competing the resider	SCC was responsible for at tracker so it could be					
	reviewed by the HWD -The HWD had only b weeks.	or ner. een in the position for 3					
		ne resident profiles were not arterly reports were not					

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