Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049029	A. BUILDING: 01 B. WING _____	R 03/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHURCHILL	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(C 000)	Initial Comments Report of Follow-up and Consultation by Dennis Harrell, Pam Houston and Greg Cates on 3-10-2015. New information came to light during the Consultation that is addressed in this Statement of Deficiencies.	(C 000)	The following is the Plan of Correction for Brookdale Churchill (formerly Emeritus at Churchill). This plan of correction is in regards to the statement of deficiencies following construction surveys on 11/19/14 and 3/10/15. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies, or any related sanction or fine. Rather, it is submitted as conformation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. Since receiving the construction section statement of deficiencies as it pertains to physical environment dated 1/26/15, the following corrections have been implemented. • Brookdale Churchill has added audible alarms to all common area doors. Effective 12/31/14. • Dead bolts locks have been installed on the applicable exterior apartment doors that lead out onto patio/courtyard area. These were applied for any residents with disorientation, wandering behaviors or known cognitive impairment effective 3/10/15. • Hourly checks have been implemented for the above mentioned residents. Hourly checks began on 10/30/14. • Residents found to need more supervision or require a secured environment have been transferred to memory care. • Magnetic locks were added to the front door on 3/9/15. Door is locked when receptionist leaves each evening. • A keypad lock was installed at the entrance of the staff lounge to restrict access to this area as well as access to the exterior exit door leading from the staff lounge to the adjacent walkway and parking lot.	
(C 101)	Existing Licensed Fac- No less than '71 Rules SECTION .0300 PHYSICAL PLANT 10A NCAC 13F .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS The physical plant requirements for each adult care home shall be applied as follows: (2) Except where otherwise specified, existing licensed facilities or portions of existing licensed facilities shall meet licensure and code requirements in effect at the time of construction, change in service or bed count, addition, renovation, or alteration; however in no case shall the requirements for any licensed facility where no addition or renovation has been made, be less than those requirements found in the 1971 "Minimum and Desired Standards and Regulations" for "Homes for the Aged and Infirm", copies of which are available at the Division of Health Service Regulation, 701 Barbour Drive, Raleigh, North Carolina, 27603 at no cost; This Rule is not met as evidenced by: Based on observation, the facility failed to properly install the Special Locking devices(magnetic locks) as required by Section 1012.6.D. if the 1996 NC State Building Code. Section 1012.6.D. requires an on/off emergency release switch, capable of interrupting power to all magnetically locked doors shall be located and properly identified at the nurse station or any	(C 101)		

3/9/15

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

STATE FORM 6899 LV sheet 1 of 3

Glenn W. Jones Executive Director 3/23/15

Division of Health Service Regulation

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{C 101}	Continued From page 1 other control station which is manned 24 hours. Special Locking devices that are not properly installed could prevent an evacuation in an emergency. Findings include: There was no central emergency release switch that could be found at the nurse station or at any other control station in the Special Care Unit which is manned 24 hours.	{C 101}	Additional plan to be implemented to bring us in compliance with DHHS is: • Add a perimeter fence along the property line of our community. • Patio doors will be added to our existing emergency call system so that they alarm to our central call system when someone exits via the patio doors. • The community will provide supervision to applicable residents who are at risk of wandering or with known disorientation until the fence and alarms are fully installed. • Upon completion, hourly safety checks will continue as indicated.... • The dead bolts will be removed from the doors after completion of the above mentioned steps. • Prior to move in, any inquiry with known disorientation, memory loss, wandering or with a diagnosis that may impair cognition, must be reviewed with the District Director of Clinical Services or the District Director of Operations to assist in determining the appropriate interventions and level of care for each individual. • For current residents, the Health and Wellness Director (HWD), Wellness Nurse (LPN) or Designee will complete an assessment of each resident at move in, within 30 days of admission, bi-annually and/or with change of condition thereafter to determine needs are met and level of care remains appropriate. Communication regarding changes in condition or the residents care needs will be made with the primary care provider and responsible party by the RN. Documentation of communication and the community's actions will be available in the resident's record.	5/1/15 4/20/15
{C 151}	Entrances/Exits-Wanderer Alarm IV. The Building C. Physical Environment (10 NCAC 42D .1503) 8. The requirements for outside entrances and exits are: d. In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each required exit door shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. A central control panel that will deactivate the sounding device may be used, provided the control panel is located in the office of the administrator. This Rule is not met as evidenced by: Based on review of documents, the facility houses at least 7 residents who have been determined by a physician to be disoriented or confused. A review of documents provided by the local Division of Social Services revealed that 2 residents have eloped in recent months far beyond the property boundaries. Interview with the local Adult Home Specialist, Ms. Kelly McMillan, revealed that other disoriented residents have left the building but were intercepted before leaving the property.	{C 151}		

Executive Director 3/23/15

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(C 151)	Continued From page 2 Based on observation, the facility failed to equip several required exit doors with sounding devices in compliance with the Rule listed above. Finding include: 1. There were at least 14 exit doors, listed on the evacuation plan and equipped with exit signs, that were not protected with a sounding device that alarms when the door is opened. 2. The staff exit door from the room designated on the evacuation plan as "Crafts" is accessible to residents and is not protected with a sounding device that alarms when the door is opened. 3. Each resident apartment has a patio door that leads directly to the outside. While these are not required exits, disoriented residents occupy some of these apartments and there are no provisions to prevent disoriented residents from wandering away. Findings on 3-10-2015: A further review of documents determined there are approximately 35 residents who have been determined by a physician to be disoriented or confused.	(C 151)	Facility Administrator will work in conjunction with DHHS and The Fire Marshal to verify a solution which will be satisfactory to all parties and meet the intended goal of providing a safe environment for our residents. **G.S. 131 D-21 (2) Declarations of Resident Rights** The community shall comply with the resident's right to receive adequate and appropriate care and services in accordance with federal and state laws, rules and regulations through oversight, supervision, training and assessment/identification of care and/or safety needs. Oversight and supervision will be ongoing and provided executive director, health and wellness director (RN), supervisors and/or designees. • Associate training and/or re-training will reflect the personalized care, preferences and safety needs of residents, including information on state regulations as it pertains to Resident Rights, Resident Care and Safety. Re-training on communication and reporting/identifying changes in condition of applicable associates will be completed by ED and RN on 2/27/15. This training will be included in future new associate orientations.	4/20/15 4/20/15 2/27/15

John W ... Executive Director 3/23/15