STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Pasquotank County Department of Social Services conducted an annual and follow-up survey and complaint investigation on February 22, 23, 24, 2017, with an exit conference via telephone on February 28, 2017.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents 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. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews, interviews, and observations, the facility failed to assure the front exit door was equipped with a sounding device that activated when the door was opened resulting in 4 of 4 sampled residents (Residents #1, # 2 and #9, who had a diagnosis of dementia and documented as intermittently disoriented and Resident #5, who was documented as constantly disoriented) to exit the facility without staff's	D 067		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JAmes Eisenhauer, ED — TITLE — (X6) DATE: 5/4/17

Reviewed & Accepted WEdwards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 1 The findings are: Observation on 02/22/17 at 12:30 p.m. of the facility entrance door revealed: -There was no alarm when the door was opened. - The entrance door opened to a parking lot at the front of the building. - The facility was situated beside a city street in a several block residental and business neighborhood. - The street ended 2 blocks away at the edge of the woods. - A private dirt road, with a posted no tresspassing sign, began where the street ended at the woods. Interview with the District Director of Clinical Services (DDCS) on 02/23/17 at 12:50 p.m. revealed: -The front door of the facility was already set up with a wander guard system. -The facility did not currently have any wander guard bracelets to use with the system. -She did not know why the facility did not have any bracelets on hand. Interviews with the DDCS on 02/24/17 at 9:30 a.m. and 02/27/17 at 12:54 p.m. revealed: -If determined a wander guard bracelet was needed, their policy was to use it for 30 days then reassess the resident. -The resident could wear the bracelet another 30 days for a total of 60 days. -Then it would be determined if the resident needed to be moved to the special care unit. -The majority of the time, a wander guard bracelet would be used when a resident had a urinary tract infection (UTI) and exit-seeking behavior. -The wander guard bracelet would be removed	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 2 once the resident had been on an antibiotic for a few days for treatment of the UTI. 1. Review of Resident #1's current FL-2 dated 08/11/16 revealed: - Diagnoses included dementia with depressive features, hypertension (HTN), transient ischemic attack (TIA), bi-lateral knee replacements, osteoarthritis, and osteoporosis. - Resident #1 was assessed as intermittently disoriented. Review of Resident #1's Resident Register dated 09/17/08 revealed, documentation the resident was "forgetful and needs reminders". Review of Resident #1's Resident Log revealed: - On 11/01/15 around 3:30 p.m., Resident #1 was very confused and kept going to the door looking for a ride to go home and was redirected by staff. - On 11/05/16 between 4:00 p.m. and 5:00 p.m., Resident #1 was found out in the facility parking lot twice looking for her car so she could go home and was irritated when the supervisor on 2nd shift tried redirecting her. - On 11/05/16 the Supervisor faxed a request to physician office for a urinalysis (UA) because Resident #1 was acting out of character and very confused, more than what was normal. - On 11/08/16 results from UA came back negative. - On 01/24/17 (time unknown), staff heard Resident #1 fussing at her roommate trying to get her out the room stating it was her room and (the resident) was paying the rent so the roommate needed to leave. Resident #1 was very upset when staff explained that she had a roommate and spent 45 minutes talking with resident and trying to calm her down. - On 02/20/17 the Personal Care Aide (PCA) on	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 3 2nd shift came in at 3:00 p.m., did her routine rounds and saw Resident #1 sitting in a lounge area with other residents, and around 3:45 p.m., she was sitting in the front lobby. - When the PCA went to get residents up and out of rooms for dinner, between 4:30 p.m. and 4:45 p.m., she noticed Resident #1 was missing. - The PCA checked resident rooms, bathrooms, shower rooms, closets and the sign in/sign out book. Interview with Business Office Coordinator (BOC) on 02/21/17 at 4:25 p.m. revealed: -Her office space was the desk located in the front lobby at the front door. - Resident #1 was observed in the lobby on 02/20/17 exact time unknown but it was after lunch. - Resident #1 was not exhibiting exit seeking behaviors on 02/20/17. - The BOC stated she did not witness Resident #1 exit the building on 02/20/17. - The BOC reported she was up and down at her desk throughout her 9am-5pm shift. - No one covered for the BOC when she left the front desk. - Resident #1 tried to exit one day, either a Tuesday or Thursday (date unknown) around 2:00 p.m., it was cold but when she was told she couldn't go out without a coat she was easily redirected to play Bingo. - Resident #1 was easily redirected; she was easy going and cooperative. - The resident would sometimes sit at the wrong dining room table but she was easily moved. - The resident used a walker and had a bad knee, it turned inward, but she was still pretty steady when she walked. - To enter the front door most people used the handicapped button to open the door to gain	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 4 access. - The front lobby door locks at 7:00 p.m. or 8:00 p.m. and alarms; this happened after she left, so she did not know what time the alarm was set. - The door was locked until the morning. Interview with Resident #1's previous roommate on 02/22/17 at 1:51 p.m. revealed: - Resident #1 was her roommate for about 3 years a while back (could not give specific timeframe). - Resident #1 did not usually go outside by herself; she always acted like she was scared of the outside. - Resident #1 was confused. - Resident #1 usually sat in the lobby area and she would go to sleep while sitting in the lobby every now and then. - Resident #1 was not in the dining room during supper on the day she went missing. -The resident thought she saw Resident #1 sitting in the lobby near the front door sometime before supper (could not recall exact timeframe). Interview with a second resident on 02/22/17 at 2:02 p.m. revealed: - Resident #1 was very pleasant and would talk to her in the lobby. - She never saw Resident #1 go to the door or outside of the facility. - Resident #1 seemed to have a problem remembering things. - Resident #1 had a walker and she walked with a limp. Interview with a medication aide (MA) on 02/22/17 at 5:07 p.m. revealed: - She came to work at 3:00 p.m. on Monday, 02/20/17. - She made rounds on the hallways and she saw	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 5 Resident #1 in her room at 3:10 p.m. - She was working as the MA on the assisted living side of the facility so she was considered the supervisor on duty. - Around 4:30 p.m. - 4:40 p.m., a PCA reported that Resident #1 was not in the dining room for supper. - They told the Administrator and staff immediately began searching inside and outside of the facility for Resident #1. - They could not find Resident #1 so the police were called. - She was not sure who called the police. - Resident #1 was confused because she would say she had to go look for her husband and staff could redirect her. - Resident #1 would sit on the porch but she would come back inside if it was cold outside. Review of the facility's Incident Report dated 02/20/17 (no time given) revealed: - PCA on the 2nd shift of the assisted living section was searching for Resident #1 approximately at 4:30 p.m. to direct her to dining room for dinner. - All community staff initiated a search inside community then outside the community. - The PCA was unable to locate Resident #1. - Resident #1 was found dead off the property on 02/21/17 (no time given). Telephone interview with the Police Lieutenant on 02/23/17 at 10:25 a.m. revealed: - The 1st call regarding the missing Resident #1 came into the 911 Center at 5:13 p.m. on 02/20/17. -Resident #1 was seen walking on a video at a nearby physician's office at 3:49 p.m. but staff didn't realize she was missing until 4:30 p.m. on 02/20/17.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 6 -The Lieutenant stated the investigation was ongoing and would not release any further details. Interview with the Police Detective on 02/24/17 at 2:25 p.m. revealed: - Their investigation was still ongoing and the police report would not be released as they are waiting on preliminary results. -The detective would not release any information on the condition of how Resident #1 body was found on 02/21/17 however the detective stated Resident# 1's body was found a little over a half mile from the facility. - According to Weather Underground, the temperature on 02/20/17 from 4:54 p.m. to 11:54 p.m. ranged from 57 degrees F. to 45 degrees F.; the temperature on 02/21/17 from 2:54 a.m. to 9:54 a.m. ranged from 39.9 degrees F. to 55.0 degrees F. Review of Resident #1's death certificate dated 02/24/17 revealed: - Resident #1's body was found in a greenhouse. - The approximate time of death was 10:43 a.m. on 02/21/17. - The immediate cause of death was pending. Telephone interview with the Executive Director (ED) on 02/21/17 at 9:06 a.m. revealed: - Resident #1 resided in the assisted living section of the facility. - Resident #1 had resided in the assisted living section of the facility for 9 years and had not wandered. - In November 2016 (no date given), Resident #1 was found in the parking lot, located in the front of the facility, looking for a car; staff redirected the resident back into the facility. - During the 2nd shift on 02/20/17 around 4:45 p.m.- 4:50 p.m. staff could not locate Resident #1	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 7 for dinner. - Staff last saw Resident #1 sitting in the front lobby of the facility at approximately 4:00 p.m. - At approximately 4:45 p.m., staff began searching the inside of the facility; Resident #1 was not found. - Before 5:00 p.m. the ED got into her personal vehicle and drove around the local area searching for Resident #1. -The physician's office near the facility had surveillance video. - Resident #1 was seen on the video, walking away with her walker, from the facility and coming towards the physician's office at 3:30 p.m. - A neighborhood resident told the ED she saw Resident #1 walking with a walker close to 4:00 p.m. going towards the end of the road which dead ends and turns into a dirt road. - The witness estimated the time Resident #1 was seen was around 4:00 p.m. - Facility staff notified family and family did not report having Resident #1 or having contact with her on 02/20/17. - The Police Department was notified shortly after 5:00 p.m. and began searching for Resident #1. - The search halted at midnight on 02/21/17 and resumed at 8:00 a.m. 2/21/17. Interview with the ED at the facility on 02/23/17 at 11:55 a.m. revealed: - Resident #1 had dementia and couldn't remember staff names and she called everyone, "Sug". - Resident #1's normal routine was to participate in activities and sit in the front lobby between meal times and activities. - Resident #1 was not displaying any behaviors and no recent incidents of wandering or exit seeking behaviors. - On 11/05/16, Resident #1 was found in the	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 8 facility parking lot looking for her car but was redirected back into the building twice; there were no further incidents. - The staff never brought any concerns regarding Resident #1 to her attention in the daily stand up meetings or collaborative care meetings which are held every 2 weeks. Interview with the ED at the facility on 02/23/17 at 4:20 p.m. revealed the facility did not complete an incident report on 11/05/16 because there was no incident; the resident was not injured. Telephone interview with the ED on 02/27/17 at 3:09 p.m. revealed: -Her staff did meal checks and night checks on the residents. -The personalized service assessments are also individualized based on each resident's needs. Interview with Health and Wellness Director (HWD), on 02/21/17 at 12:08 p.m. revealed: - The HWD last saw and spoke with Resident #1 in the front lobby on 02/20/17 at 4:00 p.m. - At 4:40 p.m., the HWD was in the medication room and the 2nd shift Personal Care Aide (PCA) entered stating she could not find Resident #1 for dinner. - A search of the entire facility including the secured unit was initiated. Review of Resident #1's office visit summary from primary care physician revealed: - Resident #1 was last seen in the office on 12/21/16 at 11:00 a.m. - The resident was diagnosed with cognitive impairment with memory loss. Attempts to contact Resident #1's physician for interview were unsuccessful.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 9 Interview on 02/23/17 at 10:15 a.m. with the ED revealed: -The facility did not have a policy on door alarms, however they had a wander control system policy which may be utilized for a resident who was assessed to be at risk for "wandering" outside the community. - When the wander guard system was activated, the front door would alarm when a resident wearing a wander guard approached it. - The system had been de-activated for some time (did not remember how long); there had been no residents who wore a wander guard. Telephone interview with Resident #1's family member on 02/24/17at 8:42 a.m. revealed: - The family member was notified by the Resident Care Coordinator (RCC) that Resident #1 was missing on 02/20/17 before 5:00 p.m. - Resident #1 had problems with confusion for years. - A previous incident occurred in 11/2016 (exact date unknown) when Resident #1 was found in the facility parking lot twice and had to be redirected back into the facility. - The family member stated after the November 2016 incident, no one from the facility spoke with them about putting a plan of supervision in place or spoke about moving Resident #1 to the memory care unit. - The family member normally visited on Sundays and his concern was that the facility did not always have someone sitting at the desk by the front door where the residents sit and there was no alarm on the front door. Interview with the ED at the facility on 02/27/17 at 9:59 a.m. revealed Resident #1 was never assessed for a wander guard, they never had any	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 10 concerns about the resident wandering. 2. Review of Resident #2's current FL-2 dated 04/26/16 revealed: -The resident's diagnoses included senile dementia and depressive disorder. -The resident was intermittently disoriented and ambulatory. Review of Resident #2's Resident Register signed on 06/26/14 revealed: -The resident was admitted to the facility on 06/30/14. -The resident was forgetful and needed reminders. Review of Resident #2's personal service plan dated 02/14/17 revealed: -The resident did not require assistance with dressing and grooming. -The resident needed reminders at times to take a shower or change clothes. -The resident was independent going to and from the dining room or community activities. -The resident walked around the community at least 3 times daily. -The resident liked to walk daily and sometimes needed to be reminded to sign out. -The resident's family member visited multiple times per week and reinforced the need for the resident to sign out. -The resident had memory loss or cognitive impairment but did not need assistance to accomplish or participate in daily routines due to memory loss or cognitive impairment. -The resident did not engage in wandering requiring redirection. Interview and observation of Resident #2 on 02/22/17 at 2:15 p.m. revealed:	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 11 -Resident #2 was in his room searching through the closet. -He was looking for his gloves and he could not remember where he put them. -He sat on the bed after looking in the closet and on other furniture in his room. -The resident took off a ball cap and sweat was beaded on his forehead. -The resident stated he had lived at the facility for about one month (admission date was 06/30/14). -The resident stated his parents would sometimes take him on trips out of the facility or he would go out by himself because his father had a job during the day. -The front door of the facility was usually unlocked and he would go outside whenever he wanted. -The rollator walker in his room belonged to him and he had it as a back-up but he could walk independently. -The resident stated his father bought the walker for Resident #1 to use when he got older. Review of Resident Log notes for Resident #2 revealed: -On 03/30/16 (no time): the resident was very confused tonight. -On 04/01/16 (2:00 a.m.): the resident was very confused and having crying spells due to the confusion and the resident asked what was wrong with him. -On 04/07/16 (10:30 a.m.): the resident was very confused, disoriented, and having crying spells. -On 05/21/16 (2:00 a.m.): the resident was up at 1:30 a.m. and he was very upset and confused. Review of a Resident Log note dated 11/09/16 at 1:45 p.m. for Resident #2 revealed: -Resident #2 stated in a loud voice that he wanted his pajamas so he could go to bed.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 12 -Resident #2 stated they took his pajamas to wash and they were not back yet. -Staff explained to the resident that it was only 2:00 p.m. and he still had to eat supper and he could lay on his bed until suppertime. Review of a Resident Log note dated 11/16/16 at 4:00 p.m. for Resident #2 revealed: -Resident #2 went to the doctor today and memory loss was consistent with dementia. -The resident was to continue taking Aricept (for Alzheimer's dementia) and to start Namenda (for Alzheimer's dementia). Review of a Resident Log note dated 11/20/16 (7 - 3 shift) for Resident #2 revealed: -Resident #2 went on a leave of absence to church. -Resident #2 left church and was walking on Highway 17 by himself. -Family was made aware. Interview with a personal care aide (PCA) on 02/22/17 at 2:50 p.m. revealed: -Resident #2 was confused but he went on walks outside all of the time. -Resident #2 would come back to the facility after he walked. -Staff "just have to keep watching" Resident #2 because of his confusion. Interview with a medication aide (MA) on 02/22/17 at 5:05 p.m. revealed: -Resident #2 was confused and forgetful. -Resident #2 left the facility by himself all of the time. -Resident #2 walked all around the facility and in the back of the facility. -Resident #2 walked down one end of the street to a physician's office and to the other end of the	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 13 street to a friend's house. -Resident #2 walked every day and he was usually gone about 10 to 15 minutes each time he left. -If Resident #2 was to be gone longer than 30 minutes, it would concern her because he was confused "most of the time". -"So far" Resident #2 had come back to the facility on his own. -The front door was usually locked at 8:00 p.m. but she was not sure what time it was unlocked in the mornings. Interview with the Administrator on 02/22/17 at 5:45 p.m. revealed: -Resident #2 had some dementia but he was usually fine during the day. -Resident #2 would get anxious at night because he did not know what he was supposed to be doing. -Resident #2 referred to his son as his father. -Resident #2 had a friend who lived about 1/8th of a mile from the facility and the resident would walk to his friend's house by himself. -Resident #2 would walk down the street to a local physician's office, which was the next building over from the facility. -A volunteer would pick up Resident #2 and other residents on Sunday to go to a local church. -In November 2016, Resident #2 left the church without telling anyone and walked back toward the facility. -A church member saw him walking back toward the facility near a local restaurant and brought him back to the facility. -The restaurant was about 1/4th mile from the church. -Now the volunteer knew to sit with Resident #2 at church because of concern he may leave by himself again.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 14 -Resident #2 had never shown he did not know where he was or where he lived to her knowledge. -Resident #2 always came back to the facility from his walks. -The front door of the facility automatically locked around 6:30 p.m. or 7:00 p.m. or 8:00 p.m. or 8:15 p.m., depending on the time of the year (i.e., daylight savings). -The front door was unlocked during the day. -When locked, if someone pulled on the handle, an alarm would sound and alerts would go to staffs' pagers. Interviews with a volunteer on 02/23/17 at 5:03 p.m. and 02/27/17 at 9:54 a.m. revealed: -She currently took Resident #2 and two other residents to a local church on Sundays. -The church was about ½ mile from the facility. -Resident #2 was familiar with the layout of the church and he would sometimes go to the bathroom by himself. -After services (usually ended around 11:30 a.m.), they sometimes visited with other church members in a common area. -She never had any reason to think he would leave on his own. -On 11/20/16, she could not find Resident #2 in the church after the service and it was "major panic". -Another church member found Resident #2 walking on Highway 17 in the direction of the facility. -Resident #2 was walking along the edge of the road (no sidewalk) in front of a restaurant that was about halfway between the church and the facility. -The church member picked up Resident #2 and took him back to the facility. -She was concerned about the danger of	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 15 Resident #2 walking so close to the traffic. -She notified the facility and the resident's family. Interview with a second MA on 02/23/17 at 4:49 p.m. revealed: -Resident #2 would forget what time of day it is and he would forget that he had eaten supper. -She had spent over 45 minutes one day trying to explain to Resident #2 that he had already eaten supper. -Resident #2 would sometimes get up 2 or 3 times during the night. -Resident #2 had tried to go out the front door a few times around 3am or 4am but she stopped him. -Resident #2 could find his room most of the time but she had to show him where his room was located a couple of times. -Resident #2 would call his friend during all hours of the early morning. -Resident #2 would go out on the front porch and he would go for walks. Interview with a third MA on 02/24/17 at 1:27 p.m. revealed she noticed when Resident #2 went out and stayed with his family for a couple of weeks, he would be confused when he came back to the facility. Interview with a fourth MA on 02/27/17 revealed: -Resident #2 had some dementia. -She tried to watch Resident #2 when he went outside on the porch. -Resident #2 sometimes went off the premises when he walked. -Resident #2 sometimes walked to a friend's house that lived up the street from the facility. -She had not known the resident to wander. -Resident #2 would sometimes repeat himself. -Resident #2 knew where his room was in the	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 16 facility and he knew how to call his family member. Interview with the District Director of Clinical Services (DDCS) on 02/23/17 at 11:30 a.m. revealed: -According to Resident #2's most current assessment and care plan, he had cognitive impairment but he did not require redirection. -Resident #2 would walk to a friend's house in the neighborhood but he did not wander. -The HWD, RCC, or Supervisor on duty were responsible for reporting elopement incidents to her. -They did not report the incident in November 2016 when Resident #2 left church during an outing and was found walking on Highway 17 toward the facility. -It should have been reported to her. -The Administrator talked with Resident #2's family member today and they were going to contact the physician about moving the resident the locked special care unit. Interview with the DDCS on 02/23/17 at 12:50 p.m. revealed: -They requested a wander guard bracelet from a sister facility today and are ordering more bracelets today. -They should get the wander guard bracelet from the sister facility today and they planned to use it for Resident #2. Observation of Resident #2's room on 02/23/17 at 1:05 p.m. revealed the room was dark and the resident was not in the room. Observation of the 100 hallway, the dining room, the living room near front door, and the lobby area from 1:06 p.m. - 1:08 p.m. revealed	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 17 Resident #2 was not in either of these common areas. Review of the Resident Sign Out Log on 02/23/17 at 1:08 p.m. revealed Resident #2 had not been signed out of the facility by anyone. Interview with the Business Office Coordinator (BOC) on 02/23/17 at 1:10 p.m. revealed: -She was not at the front desk from 12:29 p.m. - 12:59 p.m. due to being on her lunch break. -The Activity Director covered the front desk for the BOC while she was at lunch. -She had not seen Resident #2 go outside while she was at the front desk. -She was not aware of him leaving the facility with anyone or signing out while she was at the desk. -She did not know the current whereabouts of Resident #2. -She would try to find out where Resident #2 was located. Observation on 02/23/17 at 1:15 p.m. from the parlor on the 200 hall of the facility revealed: -Resident #2 was walking around in the grass behind the facility. -Resident #2 walked into an opening into the woods between some trees and disappeared into the woods. -Resident #2 was walking independently without a walker. -Resident #2 was alone and no staff were visible. Interview with the Administrator on 02/23/17 at 1:16 p.m. revealed: -When the surveyor reported the location of Resident #2, the Administrator was not aware Resident #2 had gone outside of the facility without supervision. -She was not aware Resident #2 would walk into	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 18 the woods behind the facility. -Staff would get him immediately. Observation on 02/23/17 at 1:20 p.m. revealed: -A staff person walked to the front porch with Resident #2 from the right side of the parking lot. -The staff person and the resident stopped on the front porch and facility staff were talking with Resident #2. -The Administrator came back inside the facility after staff had redirected Resident #2 to the front porch. Interview with the Activities Director on 02/23/17 revealed: -She sat at the front desk while the BOC was at lunch today. -She saw Resident #2 go outside to the front porch a couple of minutes prior (around 12:57 p.m.) to the BOC returning from lunch. -That was Resident #2's normal routine. -She was not aware that Resident #2 should not go outside unsupervised. Observation on 02/23/17 at 3:15 p.m. of the back and right side grounds areas of the facility where Resident #2 had walked into the wood unsupervised revealed: - The back of the facility had a flat, thick, grassy area about 50' between the building and the woods - On the right side of the facility (visible from the conference room/screened-in porch) was a 4' to 6' wide drainage ditch with 2' sloping sides and containing water at various depths from a few inches to the top of the 2' sides. - The drainage ditch ran from the side at the front parking lot of the facility to the adjacent property at the back right of the facility. - The facility side of the drainage ditch was open	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 19 area with cut grass up to 2' of the edge of the ditch. - The other side of the ditch was wooded, broken limbs of trees and small rocks lay scattered across the ditch in several areas. - There was an 8' wide cleared opening between the woods and the woody upper section of the drainage ditch behind the facility on the right. - From the facility the opening looked like a path into the woods. - Beyond the opening were woods on the left, a large development of high rise apartments located 50 yards ahead and to the right. - A large pond, 60 yards long x 20 yards wide was situated between the apartment buildings and the right side woods where the drainage ditch curved to the right. - The pond had no distinct top edges, the wet, muddy ground sloped about 6' into the water's edge. - The ground around the wet area was slippery. Interview with the Health and Wellness Director (HWD) on 02/23/17 at 5:30 p.m. revealed: -Resident #2 was oriented to self but he was forgetful. -Resident #2 would forget days of the week or he would forget that he had talked with a family member. -Resident #2 would get tearful and wanted to go home with his family to work on the farm. -Resident #2 would ask why his family member had not come to pick him up. -She felt Resident #2 was safe to go out into the community on his own but as with anyone there was a concern that he could get hit by a car. -She was not aware Resident #2 referred to his son as his father. Interview with the Resident Care Coordinator	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 20 (RCC) on 02/23/17 at 5:40 p.m. revealed: -Resident #2 could be "sharp as a tack" one moment but then could not remember what day to put his laundry out or which buttons to press on the television remote control. -Resident #2 would get frustrated and anxious and he would say, "What am I supposed to do?" -Resident #2 walked outside by himself frequently depending on the weather. -Resident #2 walked to a friend's house down the street from the facility. -The road in front of the facility "scares" her because there was no sidewalk and there was a curve in the road. -The resident had to walk on the edge of the road to go to his friend's house since there was not sidewalk and she was concerned a car may come speeding down the road around the curve and not see the resident in time to stop. -Resident #2 walked around the facility but he would not go into the woods. Interview with the Administrator on 02/23/17 at 6:05 p.m. revealed: -They had received the wander guard bracelet from the sister facility. -Resident #2 and the DDCS were in the Administrator's office currently and the DDCS was showing the bracelet to the resident and explaining how it worked. Observation on 02/23/17 at 7:00 p.m. revealed Resident #2 was in the lobby area and he was wearing a wander guard bracelet. Review of a letter faxed to the facility from Physician A for Resident #2 on 02/23/17 revealed: -Resident #2 had never been a wanderer. -When living with the resident's family, there had been no problems.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 21 -After discussing with family member today, the family felt there was no problem with wandering. -Resident #2 had either mild dementia or pseudobulbar affect from cerebral vascular disease. -Therefore, to walk outside of the facility at this time is of no concern. -If more information was needed, the physician noted to call him. Interview with the Administrator on 02/23/17 at 4:05 p.m. revealed: -She asked Physician A today if he felt Resident #2 was at risk for elopement or wandering. -Physician A told the Administrator there had been improvement with new medications for the resident in the last 18 months. -She did not tell Physician A about the incident in November 2016 when Resident #2 left a local church without supervision and was found walking down Highway 17 toward the facility. -She could not recall if she told Physician A that Resident #2 would refer to his son as his father. Interview with Physician A for Resident #2 on 02/24/17 at 8:30 a.m. revealed: -He had not seen Resident #2 for a medical visit since September 2016. -Resident #2 used to live with a family member and the family member said the resident walked and enjoyed being outside. -Resident #2 had some mild dementia. -Resident #2 seemed "pretty much with it" in regards to surroundings. -Resident #2 may also have some vascular dementia. -Resident #2 had pseudobulbar affect with a lot of crying spells and he started a new medication to treat it last year. -He did not have any record of the incident in	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 22 November 2016 when Resident #2 left a local church unsupervised and was found walking down Highway 17 toward the facility. -He thought since the resident had some forgetfulness and confusion, it would be good to use a wander guard bracelet for the resident. Review of an order from Physician A dated 02/24/17 revealed: -The physician wrote an order for wander guard (to prevent wandering). -The physician wrote the resident had dementia or pseudobulbar affect. -The wander guard was for prophylactic or prevention. Review of a letter faxed to the facility from Physician B's office for Resident #2 on 02/25/17 revealed due to the resident's diagnoses of dementia, the resident required "attendant when he is off of Brookdale property at all times". Interview with the Medical Receptionist for Physician B's office on 02/27/17 at 4:27 p.m. revealed: -Physician B was out of state and unavailable for interview. -She heard back from the physician on Saturday, 02/25/17, and she contacted the facility regarding Resident #2 the same day, 02/25/17. -Physician B texted the following response related to Resident #2, "he is able to leave but not alone, requires attendant and cane or walker". -The physician asked her to type a letter and fax the information to the facility since he was out of state until Wednesday, 03/01/17. -She spoke with a female at the facility to relay the information but she could not recall the name of the person she spoke with on Saturday, 02/25/17.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 23 -She would check with Physician B again to clarify whether Resident #2 needed supervision when outside on the premises of the facility. Interview with the Administrator on 02/27/17 at 12:54 p.m. revealed: -A faxed letter from Physician A's office was received yesterday noting Resident #2 required an attendant when off the facility's property. -She had worked at the facility for about 9 years and the wander guard system had been installed in the facility since she started working there. -They had used the wander guard system years ago but not recently. -The last time the facility ordered a wander guard bracelet was in 2014. -The wander guard bracelets were only good for about 1 to 2 years and then they would expire. -The bracelets came already programmed for the wander guard system at the facility and each bracelet had an expiration date on them. -Once activated, the batteries could not be changed and the bracelet would expire. -The facility's policy for using the wander guard system was if they had a resident with a change in condition, such as trying to exit-seek, they would communicate with the DDCS and the physician to evaluate if a wander guard bracelet was a safe measure or appropriate for the resident. -The wander guard bracelet they got from a sister facility for Resident #2 would expire in 2018. -Staff were checking Resident #2's wander guard bracelet every shift to make sure it was in place and documenting the checks on the MARs. Review of a letter faxed to the facility from Physician B's office for Resident #2 on 02/27/17 revealed due to the resident's diagnoses of dementia, the resident required "an attendant at	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 24 all times on and off of Brookdale property". Interviews with the DDCS on 02/24/17 at 9:30 a.m. and 02/27/17 at 12:54 p.m. revealed it was not unusual behavior for Resident #2 to take walks around the facility and in the neighborhood so a wander guard bracelet had not been used prior to this survey for Resident #2. Interview with Resident #2's family member on 02/23/17 at 7:40 p.m. revealed: -Resident #2 had lived at the facility since 2014. -He visited the resident 2 to 3 times a week. -Resident #2 had a bit of dementia and some days he was forgetful. -Resident #2 sometimes thought this family member was his brother but he was not the resident's brother. -Resident #2 did not remember how long he had lived at the facility. -He was aware Resident #2 would take walks outside of the facility. -He was aware Resident #2 would walk to a friend's house up the street from the facility. -Resident #2 managed to walk up the street and back to the facility. -He did not think Resident #2 would depart from the main street. -The Administrator talked with him about using the wander guard bracelet for Resident #2 today and doing "buddy" walks. -He was in agreement with whatever it took to keep Resident #2 safe. 3. Review of Resident #9's current FL2 dated 8/12/16 revealed: -Her diagnoses included senile dementia uncomplicated, neurohyphosis, and tachycardia. -Resident #9 was intermittently disoriented.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 25 Review of the Resident Register for Resident #9 revealed he was admitted to the facility on 2/4/14. Review of the Licensed Health Professional Support evaluation dated 1/18/17 for Resident #9 revealed: -Resident #9 was described in the Health Status Review as being alert with some short term and long term memory deficits. -Resident #9 was "pleasantly confused per normal". Interview with a Personal Care Aide (PCA) on 2/24/17 at 12:55pm revealed: -As she walked through the facility hallway and passed by the front lobby, she spotted Resident #9 out on the front porch unaccompanied. -The resident was starting to walk off the porch when she walked over and redirected the resident back into the facility. -The door was not set to alarm and there was no staff person stationed in the lobby. -She could not recall the date of the incident, but she did recall that it was warm outside during that time. Interview with a Medication Aide (MA) on 2/24/17 at 3:55pm revealed: -Resident #9 had been allowed to go out on the porch and sit in the rocker, without staff. She had never been told the resident could not sit on the porch. -Resident #9 was confused most of the time and would be looking for her truck. Review of the Resident Log for Resident #9 revealed: -On 9/16/16 Resident #9 was found in the back parking lot of the facility, by the Maintenance Director around 5:00pm. The resident was	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 26 wandering around in the parking lot by herself. -The Maintenance Director called into the facility and spoke with a MA. -The MA went outside and redirected the resident back into the facility. -On 11/5/16 between 7:00am and 3:00pm, Resident #9 walked out of the front door alone and unaccompanied. As Resident #9 was walking outside, her family member pulled up at the facility and took her out for a while. Interview with the Health and Wellness Director (HWD) on 2/27/17 at 12:50pm revealed, there was one occasion of Resident #9 being in the front of the building walking down to the end of the sidewalk. She did not know the date of the incident. Interview with the Administrator on 2/27/17 at 3:00pm revealed: -Resident #9 had been confused since she was admitted in 2014. -Resident #9 sat out on the porch frequently with a small group of residents. -She was aware of a couple of incidents where Resident #9 had wandered beyond the porch of the facility and had to be redirected back into the facility by staff. -Resident #9 had "never gotten off the property". -She was aware of an incident back in September 2016, when Resident #9 walked out the front door of the facility, along the sidewalk of the facility to the back. -The resident was redirected back into the facility by the Maintenance Director. -She recalled another incident in November or December 2016 when she saw the resident walk outside alone, to the end of the sidewalk near the screened in porch, she redirected the resident back into the facility.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 27 -She could not recall the exact dates or times of those incidents. -As of 2/23/17 Resident #9 was being considered for a wander guard. -She spoke with a family member of Resident #9 on 2/26/17, and discussed taking Resident #9 to the physician and obtaining a physician order for a wander guard for the resident. 4. Review of Resident #5's current FL2 dated 2/18/17 revealed: -Her diagnoses included a history of a hip fracture, respiratory failure and hypoxia. -Resident #5 was constantly disoriented. Review of the Resident Register for Resident #5 revealed he was admitted to the facility on 3/28/16. Review of Resident Log for Resident #5 dated 2/1/17 revealed: -Around 1:15pm Resident #1 had to be redirected back inside the building. -The resident had said she was going home. Interview with a Personal Care Aide on 2/24/17 at 1:05pm revealed: -About one and a half weeks to two weeks before Resident #5 was moved to the memory care unit, at a little after 1:00pm she saw Resident in the front parking lot. She went out redirected the resident and brought the resident back in the facility. -Resident #5 had walked out of the front door. Interview with a Medication Aide on 2/24/17 at 3:55pm revealed: -Resident #5 was "always confused". -Resident #5 "walked out of the front door and went down the road 3 or 4 weeks ago, in the	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 28 middle of the day". Interview with the Administrator on 2/27/17 at 3:00pm revealed on 2/2/17 or 2/3/17 (not sure which) Resident #5 had walked out the front door and was seen walking in the front parking lot. Interview with the Health and Wellness Director on 2/27/17 at 12:50pm revealed: -Resident #5 had been moved to the memory care unit on 2/18/17, because she had been exit seeking, and had exited the facility unaccompanied on one occasion that she was aware of. -On 2/1/17 Resident #5 had exited out of the front door without assistance. The resident was in the driveway, when staff saw her and brought her back inside of the facility. On 2/22/17 the Executive Director provided a Plan of Protection for residents, "front door will be locked and alarmed. Doors will be locked and alarmed immediately. Front desk will have a staff member at the desk at all times when the front door is not alarmed". 5. Observation on 2/23/17 at 8:05 am of the facility front door and lobby revealed: - Upon entering the facility, the front door was unlocked, no alarm sounded as the door was opened. - The lobby was empty, there was no staff at the front desk. - There were no staff visible in the facility hallways. - Fifteen residents were visible through the glass windows of the adjoining dining room having breakfast. - The Dietary Manager (DM) was assisting serving the meal and had her back to the front lobby.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 29 - At 8:08 am, the DM turned around, saw the surveyors standing in the lobby, and took some dishes into the kitchen, and came out of the dining room into the lobby. Interview on 2/23/17 at 8:10 am with the DM revealed there was no front desk staff until 9 am in the mornings. Interview on 2/23/17 at 8:11 am with a PCA on the 200 hall revealed: - The PCA did not know what time the front door was unlocked. - There were 3 PCAs and 1 medication aide (MA) working in the assisted living this morning. Observation on 2/23/17 at 8:25 am of the front lobby revealed: - There was no staff at the front desk, no staff at the front entry way. - At 8:27 am, the PCA came from the right hallway, answered the phone at the front desk, and returned back down the hallway. - At 8:28 am, a resident using a rollator came out of the dining room, headed to the front door, pushed the handicapped door release on the wall, went out the door to the front porch. - No alarm had sounded as the door automatically opened. Observation on 2/23/17 at 8:35 am of the front desk and lobby revealed: - There was no staff at the front desk, no staff at the front entry way. - A 2nd resident walked slowly out of the dining room up to the front desk, paused, looked outside, then walked away. Observation on 2/23/17 at 8:38 am of the front	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 30 door and lobby revealed: - The 1st resident who went outside to smoke pushed the outside door release, entered the building and went down a hallway. - There was no staff at the front desk, no staff at the front entry way. Observation on 2/23/17 at 8:48 am of the front desk and entryway revealed: - There was no staff at the front desk, no staff at the front entry way. - A 3rd resident using a rollator came to sit in a chair in the lobby that faced the front door. - At 8:49, a 4th resident with a walker, came into the front center entryway, about 4 feet away from the front door, paused for 1 minute looking out the front door, then turned around and walked on down the hall. - At 8:51 am a 5th resident using a walker came into the entryway, walking very slowly and leaning forward, paused 3 feet away from the front door, looked out fot 45 seconds, turned around, went to a chair and attempted to sit, then walked away. Interview 2/23/17 with the Executive Director at 8:55 am revealed: - The front desk staff came in at 9:00 am. - Last night (2/22/17) she set the front door to lock at 6 pm and to unlock at 9:00 am. - The ED was not aware the door was unlocked this morning. - The door should have stayed locked until 9 am this morning until I came in. - The Business Office Coordinator (BOC) was at the front desk (her office) from 9 am to 5:30 pm. - The ED would check with staff to see what happened, why the door was unlocked. - The door would not alarm if the wander control system was not activated. - The wander control system had not been	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 31 activated in a while, she did not remember how long. - No residents had been using a wander guard. - The door would not alarm when opened. Interview on 2/23/17 at 9:05 am with the Business Office Coordinator (BOC) revealed: - There was not any staff at the front desk until she came in to work. - Her hours were from 9 am to 5 pm. - In the mornings, residents were at breakfast from 7 am to 9 am. - The door lock system was overridden by staff to unlock. - No time was given for when the front door was unlocked. Interview on 2/23/17/at 4:05 pm with the Maintenance Technician (MT) revealed: - The times for locking and unlocking the front door did not work. - The front door was not locked between 6 pm on 2/22/17 and 9 am on 2/23/17. - He called the system manufacturer and was told the system had not made the change of locking at 6 pm on 2/22/17 to 9 am on 2/23/17 because the system was older. - A reset of the system must be done in order for the system to program new times. - The MT performed the locking system reset and the front door was now set to lock at 6 pm until 9 am the next morning. The facility failed to have door alarm sounding devices activated on the front entrance door when the door was unlocked to prevent residents who had dementia, confusion, and who were intermittently disoriented, known to be wanderers, from exiting the facility. Resident #1, diagnosed	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 32 with dementia and confusion, resided in the assisted living section, eloped from the facility, unobserved, twice in November 2016. The resident eloped from the facility the late afternoon of 02/20/17, unobserved by staff. Resident #1 was found by police the next day, 02/21/17, deceased about a half mile from the facility. Three additional residents with diagnoses of confusion/disorientation were able to leave the facility unsupervised. The failure of the facility to assure exit doors were equipped with a sounding device for residents who are known to be disoriented or a wanderer constitutes a Type A1 Violation. _____ The Executive Director provided a "Plan of Protection" for all residents effective 2/24/17: - The front door will be alarmed and locked from 6 pm to 9 am daily. - There will be a staff member at the front desk at all times between 9 am to 6 pm. - Residents identified with dementia/intermittently disorientation will have a wander guard placed on their ankle, which will lock the front door when exiting. - That in return, will alert the staff to where the resident is. - Wander guard will lock the front door when the resident tries to exit; the alarm will go off and alert the staff on their pagers. - Wander guards have been ordered for residents with a diagnosis of dementia with intermittently disorientation. - Staff will contact the Executive Director, Health & Wellness Director, and the Medical Doctor, and family if a resident's confusion increases, so resident can be evaluated by their physician to see if a special care unit will be appropriate. - Wander guard checks will be monitored on each	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 33 shift by the SIC (Supervisor) and documented that they are working. - The Executive Director will check daily for compliance. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 30, 2017.	D 067		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure the residents' physicians certified their care by signing and dating care plans within 15 days of assessment for 6 of 6 sampled residents (#1, #2, #3, #4, #5, #9). The findings are: 1. Review of Resident #1's current FL-2 dated 08/11/16 revealed: - Diagnoses included dementia with depressive features, transient ischemic (brief stroke-like) attacks,	D 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 263	Continued From page 34 hypertension, bilateral knee replacements, osteoarthritis (degenerative joint disease), osteoporosis (condition of weak, brittle bones). Review of Resident #1's Resident Register revealed an admission date of 01/17/08. Review of Resident #1's record revealed: - A Personal Service Plan (PSP) was completed on 10/20/16. - The resident required assistance with dressing and grooming; she was unable to remember to complete tasks. - The resident was incontinent of bowel and bladder and needed assistance with toileting. - The resident used a walker for ambulation and often had pain in her knees. - Resident #1 needed staff assistance due to memory impairment. - The document was signed and dated by the Health and Wellness Director (HWD). - There was no signature and date by the resident's physician. The resident was recently deceased. Interview on 02/24/17 at 3:35 p.m. with the Health and Wellness Director (HWD) revealed: - The signature page was missing for Resident #1's PCP, the person who had the HWD position before her must have not completed the signatures. - The current HWD started her position in November of 2015. - The HWD flipped through the resident's record and did not locate a signature page with the physician's signature and date. - The HWD stated she would try to locate the document, but did not return with a signature page with the physician's signature and date.	D 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 263	Continued From page 35 Refer to interview with the Health and Wellness Director (HWD) on 02/24/17 at 12:10 p.m. Refer to interview with the Resident Care Coordinator (RCC) on 02/28/17 at 12:02 p.m. Refer to interview with the HWD on 02/27/17 at 11:18 a.m. Refer to interview with the Administrator on 02/28/17 at 9:55 a.m. 2. Review of Resident #4's current FL-2 dated 8/20/16 revealed: - Diagnoses included dementia, lumbar pain, and arthritis. - The resident was constantly disoriented, needed assistance with bathing and dressing, and was incontinent of bowel and bladder. Review of Residents #4's Resident Register revealed an admission date of 01/05/13. Review of Resident #4's record revealed: - A Personal Service Plan (PSP) completed on 01/13/17. - The resident required total assistance with dressing and grooming, and toileting. - The resident needed assistance with bathing the upper and lower body. - Toileting assistance was needed for pulling pants up and down, use of toilet paper and cleansing, and changing of protective undergarments. - The resident required physical assistance related to the inablility to stand independently during bathroom tasks. - The resident required physical assistance to and from the dining room and community activities.	D 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 263	Continued From page 36 - The resident was non-ambulatory, 2-person assist was utilized for a mechanical lift for all transfers due to non weight bearing status. - The resident was not always oriented to time or place. - The resident had difficulty communicating needs and preferences (verbally or non-verbally). - There was a signature and date by the facility registered nurse (RN) completing the PSP. - There was no signature and date by the attending physician. Based on observation, interviews, and record review, the resident was determined not to be interviewable. Observation on 02/23/17 at 1:31 p.m. of Resident #4 revealed: - The resident was seated in her wheelchair beside the bed in her room. - The resident was transferred to her bed by 2 staff using a mechanical lift. Interview on 02/24/17 at 3:30 p.m. with the Health and Wellness Director (HWD) revealed: - The HWD was responsible for completing residents' PCPs and obtaining the physicians' signatures. - She usually attached a separate signature page to the back of the PCP. - There was not a signature page on the back of the PCP for Resident #4. - She would try to locate the signature page. Refer to interview with the Health and Wellness Director (HWD) on 02/24/17 at 12:10 p.m. Refer to interview with the Resident Care Coordinator (RCC) on 02/28/17 at 12:02 p.m.	D 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 263	Continued From page 37 Refer to interview with the HWD on 02/27/17 at 11:18 a.m. Refer to interview with the Administrator on 02/28/17 at 9:55 a.m. 3. Review of Resident #9's current FL-2 dated 08/12/16 revealed: - Diagnoses included tachycardia, hypothyroidism, osteoporosis, senile dementia, and anemia. - The resident was intermittently disoriented and required assistance with bathing. Review of the Resident Register for Resident #3 revealed he was admitted on 02/04/14. Review of Resident #9's PCP dated 02/02/17 revealed: - The resident required set up assistance with dressing and grooming. - The resident required assistance with bathing. -The resident was incontinent of bladder, but did not require toileting assistance. -The resident was able to communicate needs and wants. -The resident was independent with ambulation and transfers, she used a walker to aid mobility. -There was a signature and date by the facility Nurse that completed the PSP. -There was no signature and date by the attending physician. Based on observation, interviews and record reviews Resident #9 was not interviewable. Refer to interview with the Health and Wellness Director (HWD) on 02/24/17 at 12:10 p.m. Refer to interview with the Resident Care	D 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 263	Continued From page 38 Coordinator (RCC) on 02/28/17 at 12:02 p.m. Refer to interview with the HWD on 02/27/17 at 11:18 a.m. Refer to interview with the Administrator on 02/28/17 at 9:55 a.m. 4. Review of Resident #3's current FL-2 dated 08/19/16 revealed: - Diagnoses included dementia, hypertension, and coronary artery disease. - The resident was constantly disoriented and required assistance with feeding, bathing and dressing; was incontinent of bladder. Review of the Resident Register for Resident #3 revealed he was admitted on 10/15/15. Review of Resident #3's PCP dated 11/09/16 revealed: -The resident required staff assistance for dressing and grooming. -The resident required assistance with bathing. -The resident was incontinent of bladder and required assistance with toileting. -The resident was not always oriented to time and place. -There was a signature and date by the facility Nurse that completed the PSP.-There was no signature and date by the attending physician. Based on observation, interviews and record reviews Resident #3 was not interviewable. Refer to interview with the Health and Wellness Director (HWD) on 02/24/17 at 12:10 p.m. Refer to interview with the Resident Care Coordinator (RCC) on 02/28/17 at 12:02 p.m.	D 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 263	Continued From page 39 Refer to interview with the HWD on 02/27/17 at 11:18 a.m. Refer to interview with the Administrator on 02/28/17 at 9:55 a.m.. 5. Review of Resident #5's current FL-2 dated 02/18/17 revealed: - Diagnoses included respiratory failure, hypoxia, left hip fracture, hypertension, and hypothyroidism. - The resident was constantly disoriented and required assistance with dressing, and bathing; was incontinent of bladder, and incontinent of bowel at times. Review of Residents #5's Resident Register revealed an admission date of 03/28/16. Review of Resident #5's PCP dated 02/18/17 revealed: -The resident required assistance with dressing and grooming. -The resident required assistance with bathing. -The resident was incontinent and required assistance with toileting. -The resident was independent to ambulate and transfer with the aid of a walker. -The resident was not always oriented to time and place. -There was a signature and date by the facility Nurse that completed the PSP. -There was no signature and date by the attending physician. Based on observation, interviews and record reviews Resident #5 was not interviewable. Refer to interview with the Health and Wellness	D 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 263	Continued From page 40 Director (HWD) on 02/24/17 at 12:10 p.m. Refer to interview with the Resident Care Coordinator (RCC) on 02/28/17 at 12:02 p.m. Refer to interview with the HWD on 02/27/17 at 11:18 a.m. Refer to interview with the Administrator on 02/28/17 at 9:55 a.m. 6. Review of Resident #2's current FL-2 dated 04/26/16 revealed: -The resident's diagnoses included senile dementia, depressive disorder, atrial fibrillation, abnormal glucose, hematuria, calculus of kidney, and acute myocardial infarction of the anterolateral wall. -The resident was intermittently disoriented. -The resident was ambulatory and continent of bowel and bladder. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 06/30/14. Review of Resident #2's personal service plans (PSP) revealed: -The resident's PSP dated 07/03/14 was not signed by a physician. -The resident's only signed PSP in the record was completed on 07/03/15 and signed by the physician on 07/08/15. -There was no PSP for 2016 for Resident #2. -There was a new PSP dated 02/14/17 that had not been signed by the physician as of 02/28/17. Review of Resident #2's only physician signed PSP dated 07/03/15 revealed: -Resident #2 was independent with eating,	D 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 263	Continued From page 41 ambulation, dressing and transferring. -Resident #2 required supervision ("reminders") with bathing and grooming. -Resident #2 required limited assistance with toileting at times. Review of Resident #2's personal service plan dated 02/14/17 revealed: -The resident did not require assistance with dressing and grooming. -The resident did not require assistance with showering or bathing. -The resident needed reminders at times to take a shower or change clothes. -The resident did not required bathroom assistance. -The resident was independent going to and from the dining room or community activities. -The personal service plan had not been signed by a physician. -The resident was oriented to person, place, and time. -The resident could communicate needs and preferences. -The resident had memory loss or cognitive impairment but did not need assistance to accomplish or participate in daily routines due to memory loss or cognitive impairment. Interview with the Health and Wellness Director (HWD) on 02/24/17 at 12:10 p.m. revealed: -She was not sure why Resident #2's care plans had not been signed by a physician since 2015. -There should be a signature page with each care plan and it should be signed annually by the physician. -She was not sure if the PSP completed on 02/14/17 had been sent to the physician for signature. -She would check on it.	D 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 263	Continued From page 42 Interview with Resident #2 on 02/22/17 at 2:15 p.m. revealed: -The resident stated he had lived at the facility for about one month (admission date was 06/30/14). -The resident stated his parents would sometimes take him on trips out of the facility or he would go out by himself because his father had a job during the day. -The rollator walker in his room belonged to him and he had it as a back-up but he could walk independently. -The resident stated his father bought the walker for Resident #1 to use when he got older. -He was independent with activities of daily living and he did not need any help by staff. Refer to interview with the Health and Wellness Director (HWD) on 02/24/17 at 12:10 p.m. Refer to interview with the Resident Care Coordinator (RCC) on 02/28/17 at 12:02 p.m. Refer to interview with the HWD on 02/27/17 at 11:18 a.m. Refer to interview with the Administrator on 02/28/17 at 9:55 a.m. --- Interview with the Health and Wellness Director (HWD) on 02/24/17 at 12:10 p.m. revealed: -She was responsible for doing the assessments and care plans for the residents. -Sometimes the transporter would deliver the care plans to physicians' offices for signature and sometimes she would mail the care plans for signatures. -There should be a signature page with each care plan and it should be signed annually by the	D 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 263	Continued From page 43 physician. -She thought the RCC may have mailed some out so she would check with her. Interview with the Resident Care Coordinator (RCC) on 02/28/17 at 12:02 p.m. revealed: -She was responsible for doing FL-2s and physician's order sheets. -She did not have anything to do with the personal service plans (care plans) for the residents. -The HWD was responsible for assessing the residents and filling out the personal service plans. -The HWD was responsible for getting the personal service plans signed by the physician. Interview with the HWD on 02/27/17 at 11:18 a.m. revealed: -She had some PSPs on her desk and the RCC sent some out to physician's offices for signature. -She did not know which ones had been sent for signature. -They had an audit tool to monitor for physician response but the tool had not been used. -She planned to do a complete audit of all resident's PSPs and update the audit tool. Interview on 02/28/17 at 9:55 a.m. with the Administrator revealed: - She realized there was a problem with residents' care plans not being signed by their physician. - She thought the HWD was getting the physicians to sign and date them. - The HWD thought the Administrator was obtaining the signatures. - She stated they were taking care of that now.	D 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 44	D 270		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews, interviews, and observations, the facility failed to provide supervision and implementation of the wander guard system in the assisted living unit, in accordance with each resident's needs, care plan, and current symptoms for 4 of 4 sampled residents (Residents #1, #2, #9) known to have dementia, were confused, disoriented, and who, unknown to staff, wandered away from the facility resulting in one resident death (#1). The findings are: Observation on 02/22/17 at 12:30 p.m. of the facility entrance door revealed: -There was no alarm when the door was opened. - The entrance door opened to a parking lot at the front of the building. - The facility was situated beside a city street in a several block residental and business neighborhood. - The street ended 2 blocks away at the edge of the woods. - A private dirt road, with a posted no tresspassing sign, began where the street ended at the woods.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 45 Interview with the District Director of Clinical Services (DDCS) on 02/23/17 at 12:50 p.m. revealed: -The front door of the facility was already set up with a wander guard system. -The facility did not currently have any wander guard bracelets to use with the system. -She did not know why the facility did not have any bracelets on hand. Interviews with the DDCS on 02/24/17 at 9:30 a.m. and 02/27/17 at 12:54 p.m. revealed: -If determined a wander guard bracelet was needed, their policy was to use it for 30 days then reassess the resident. -The resident could wear the bracelet another 30 days for a total of 60 days. -Then it would be determined if the resident needed to be moved to the special care unit. -The majority of the time, a wander guard bracelet would be used when a resident had a urinary tract infection (UTI) and exit-seeking behavior. -The wander guard bracelet would be removed once the resident had been on an antibiotic for a few days for treatment of the UTI. 1. Review of Resident #1's current FL-2 dated 8/11/16 revealed: - Diagnoses included dementia with depressive features, and bi-lateral knee replacements. - Resident #1 was assessed as intermittently disoriented. Review of Resident #1's Resident Register dated 9/17/08 revealed: "Memory"- was forgetful and needed reminders. Review of Resident #1's Resident Log revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 46 - On 11/1/15 around 3:30 pm Resident #1 was very confused and kept going to the door looking for a ride to go home and was redirected by staff. - On 11/5/16 between 4:00 pm and 5:00 pm Resident #1 was found out in the facility parking lot twice looking for her car so she could go home and was irritated when the supervisor on 2nd shift tried redirecting her. - The Supervisor faxed a request to physician office for a urinalysis (UA) on 11/5/16 (time unknown) because Resident #1 was acting out of character and very confused. - Results from UA came back negative on 11/8/16. - On 1/24/17 (time not documented), staff heard Resident #1 fussing at her roommate, trying to get her out the room stating it was Resident #1's room, she was paying the rent so the roommate needed to leave. - Resident #1 was very upset when staff explained that she had a roommate and spent 45 minutes talking with resident and trying to calm her down. - On 2/20/17, a Personal Care Aide (PCA) on 2nd shift came in at 3pm and did her routine rounds, checking on everyone, and saw Resident #1 with other residents. - Around 3:45 pm the resident was sitting in the front lobby. - The Business Office Coordinator (BOC) sat at the front desk, but she was up and down and not consistently sitting at the desk throughout hser shift of 9 am to 6 pm. - The PCA went to get residents up and out of rooms for dinner and noticed Resident #1 was missing. - The PCA checked resident rooms, bathrooms, shower rooms, closets and the sign in/sign out book.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 47 Review of the facility's Incident Report dated 2/20/17 (no time given) revealed: - The PCA on the 2nd shift of the assisted living section was searching for Resident #1 at approximately 4:30 pm to direct her to the dining room for dinner and was unable to locate her. - All community staff initiated a search for the resident inside community then outside community. - Resident #1 was found dead off the property on 2/21/17 (no time given). Telephone interview with the Police Lieutenant on 2/23/17 at 10:25am revealed: - The 1st call regarding missing Resident #1 came into the 911 Center at 5:13pm on 2/20/17. - Resident #1 was seen on a security video taken at a nearby physician's office walking by at 3:49 pm, but staff did not realize she was missing until 4:30 pm on 2/20/17. - The Lieutenant stated the investigation was ongoing and would not release any further details. - According to Weather Underground, the temperature on 2/20/17 from 4:54 pm to 11:54 pm ranged from 57.0 degrees F. to 45.0 degrees F.; on 2/21/17 the temperature from 2:54 am to 9:54 am ranged from 39.9 degrees F. to 55.0 degrees F. - Interview with the Police Detective on 2/24/17 at 2:25 pm revealed their investigation was still ongoing and the police report would not be released as they are waiting on preliminary results. - The detective stated Resident #1's body was found on 2/21/17 a little over a half mile from the facility. Review of Resident #1's death certificate dated	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 48 2/24/17 revealed: - Resident #1's body was found in a greenhouse and the approximate time of death was 10:43am on 2/21/17. - The immediate cause of death was pending. Telephone interview with Medical Examiner on 2/24/17 at 9:19am revealed cause of death is listed as pending and could take several months before a cause of death is listed because of further studies and slides that were done and sent off for testing. Review of Resident #1's office visit summary from her primary care physician revealed: - Resident # 1 was seen in the office on 12/21/16 at 11:00am and was seen for respiratory diagnosis of infection. - The physician also added cognitive impairment with memory loss as a diagnosis on 12/21/16. The medical provider lists other diagnoses as: pre-senile dementia with depression without behavioral disturbance, vitamin D deficiency, essential hypertension, and congenital hypothyroidism without goiter. Attempts to contact Resident #1's physician for interview were unsuccessful. Interview with the Business Office Coordinator (BOC) on 2/21/17 at 4:25 pm revealed: - Her office space was the desk located in the front lobby at the front door. - Resident #1 observed in the lobby on 2/20/17 exact time unknown but it was after lunch. - Staff reported she was up and down throughout her 9am-5pm shift. - Resident #1 was not exhibiting exit seeking behaviors on 2/20/17. - The BOC did not witness Resident #1 exiting	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 49 the community on 2/20/17. - The BOC reported she was up and down and away from her desk throughout her 9 am to 5 pm shift. - Staff did not relieve the BOC when she was away from her desk. - Resident #1 was sitting in a chair with her back to the dining room in the front lobby. - Resident #1 tried to exit one day, either a Tuesday or Thursday (date unknown) around 2:00 pm, it was cold but when she was told she couldn't go out without a coat she was easily redirected to play BINGO. - Resident #1 was easily redirected; she was easy going and cooperative. - Resident #1 seemed "status quo no declines", nothing about her behavior on 2/20/17 stood out. - Resident #1 would sometimes sit at the wrong dining room table but she was easily moved. - Resident #1 used a walker and had a bad knee it turned in but she was still pretty steady when she walked. Resident #1 didn't ambulate as slowly as some residents. -To enter the front door most people use the handicapped button to open the door to gain access although some people ring the doorbell. The front lobby door locks at 7:00 pm or 8:00 pm and alarms; this happens after she leaves so she is not exactly sure what time the alarm is set. Telephone interview with Executive Director (ED), on 2/21/17 at 9:06 am revealed: - Resident #1 resided in the assisted living section of the facility. - Resident #1 was 90 years old and ambulated with a walker. - Resident #1 ha resided in the assisted living section of the facility for 9 years and had not wandered. - In November 2016 (no date given), Resident #1	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 50 was found in the parking lot, located in the front of the facility, looking for a car; staff had to redirect the resident back into the facility. - During the 2nd shift on 2/20/17 around 4:45 pm to 4:50 pm, staff could not locate Resident #1 for dinner. - Staff last saw Resident #1 sitting in the front lobby of the facility at approximately 4:00 pm. - At approximately 4:45 p.m. staff began searching the inside of the facility; Resident #1 was not found. - Before 5:00 p.m. ED got into her personal vehicle and drove around the local area searching for Resident #1. - The physician's office near the facility had surveillance video and Resident #1 was seen on the video walking away from the facility and coming towards the physician's offic eat 3:30 pm. - A neighborhood resident told ED she saw Resident #1 walking with a walker close to 4:00 p.m. going towards the end of the road which dead ends that turns into a dirt road. - The witness estimated the time the resident was seen was around 4:00 p.m. - Facility staff notified family and family did not report having Resident #1 or having contact with her on 2/20/17. - The Police Department was notified shortly after 5:00 p.m. and began searching for Resident #1. Police and staff searched in the neighborhoods, fields, woods, golf course to include riding the edge of the golf course in a golf cart. - Nearby restaurants and stores were also searched. - Helicopters and all-terrain vehicles were added to the search. - Search halted at 11:5p pm on 2/21/17 and resumed at 8:00 a.m. 2/21/27. - A police detective and the maintenance	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 51 personnel searched every square inch of the facility. Interview with Health and Wellness Director (HWD), on 2/21/17 at 12:08 pm revealed: - The HWD last saw and spoke with Resident #1 in the front lobby on 2/20/17 at 4:00 pm. - At 4:40 pm the HWD was in the medication room. - The 2nd shift resident aide (RA) entered stating she could not find Resident #1 for dinner. - A search of the entire facility including the secured unit was initiated; closets, under beds, all porches, parlors and shower rooms were searched. - The Resident Care Coordinator (RCC) notified Resident #1's family. - The Search moved outside and Resident #1's family member arrived. - The Executive Director (ED) contacted the police and Resident #1's doctor. - Two or three sweeps of the inside of the facility were performed before the police arrived. - The HWD continued to search outside until after dark or around 5:35 pm. - The front of the facility was searched, by the pond, in the tree line, and timber around the entire facility and by the nearby apartment complex. - The convenience store, fast food restaurants, and grocery store were all checked. - Outside the physician's office, a passerby stated the resident had been observed walking straight down the paved road. - Facility staff searched in cars in the parking lot and the facility bus. - The ED and a Medication Aide (MA) for the secured unit drove down the dirt driveway at the end of the paved road looking for Resident #1. - Resident #1 required assistance with showering	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 52 and dressing. Resident #1 could brush teeth, wash face and ambulate with a walker independently. - Resident #1's gait was unsteady and if walking on an uneven surface Resident #1 would probably fall. Resident #1's right knee was bent uncomfortably. - Resident #1 was alert, oriented but forgetful and had a dementia diagnosis. - On an earlier occasion Resident #1 informed staff that she was "looking for a car" but she never got up and went to door. - This is only episode known to HWD. - Resident #1 did not exhibit exit seeking behavior. - The HWD never heard her say, "Let me out" or "I want to go home". - Resident #1 had not experienced any significant changes in the last 6 months. Interview with staff, Program Coordinator (PC) on 2/21/27 at 3:02 pm revealed: - Resident #1 was pretty involved in activities when coaxed. - Resident #1 was a "sitter" but when coaxed she would get up and participate in activities. - Resident #1 was forgetful but easy to redirect and easy to keep involved in small groups with structure. - Resident #1 would periodically say, "Well Sug, got to get my car and go get mom". - About 3 months ago Resident #1 started to be slower to respond mentally. - Resident #1 liked non-stressing activities the best like morning announcements, daily chronicles, joke and then exercise. - She did well with exercise despite her really bad leg; her knee was misaligned. - Resident #1 recently moved to a different room on the same 300 hall and did well with the move.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 53 - Moved to a different room on the same (300) hall. - Resident #1 did well with the new roommate. - On 2/20/17, the Program Coordinator(PC) and Special Care Unit Director (SCD) entered the front lobby and observed Resident #1 in a high back chair, in the lobby, about 3:55 pm. - Dinner started at 5:00 pm and staff started getting people for dinner at 4:30 pm. - It ccould take an entire 30 minutes to get some residents from their rooms to the dining room. - On 2/20/17 at 4:45 pm, staff noticed Resident #1 was not accounted for. - The facility initiated protocols to find a missing resident. - The PC searched the 100 hall 1st followed by the 200 and 300 halls. - The PC and BOC searched outside the facility; a neighborhood resident reported seeing Resident #1 at around 4:10 pm walking away from the facility down the road. - The PC revealed Resident #1 never took herself for a walk; the resident would sit on the porch, but staff had no fear of her leaving. - Resident #1's gait "was awful", so staff did not fear her going far. Interview with a resident on 02/22/17 at 1:51 p.m. revealed: - Resident #1 was her roommate for about 3 years a while back (could not give specific timeframe). - Resident #1 was not her roommate when Resident #1 went missing. - She read about what happened to Resident #1 in the newspaper. - Resident #1 did not usually go outside by herself; she always acted like she was scared of the outside. - Resident #1 was confused.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 54 - Resident #1 usually sat in the lobby area and she would go to sleep while sitting in the lobby every now and then. - Resident #1 was not in the dining room during supper on the day she went missing. -The resident thought she saw Resident #1 sitting in the lobby near the front door sometime before supper (could not recall exact timeframe). Interview with a second resident on 02/22/17 at 2:02 p.m. revealed: - Resident #1 was very pleasant and would talk to her in the lobby. - She never saw Resident #1 go to the door or outside of the facility. - Resident #1 seemed to have a problem remembering things. - Resident #1 had a walker and she walked with a limp. Interview with a Medication Aide (MA) on 02/22/17 at 5:07 p.m. revealed: - She came to work at 3:00 p.m. on Monday, 02/20/17. - She made rounds on the hallways and she saw Resident #1 in her room at 3:10 p.m. - She was working as the MA on the assisted living side of the facility so she was considered the supervisor on duty. - Around 4:30 p.m.- 4:40 p.m., a Personal Care Aide (PCA) reported that Resident #1 was not in the dining room for supper. -They told the Administrator and staff immediately began searching inside and outside of the facility for Resident #1. -They could not find Resident #1 so the police were called. - She was not sure who called the police. - Resident #1 was confused because she would say she had to go look for her husband and staff	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 55 could redirect her. - Resident #1 would sit on the porch but she would come back inside if it was cold outside. Interview on 2/21/17 at3:35 pm with a 2nd shift personal care aide (PCA) revealed: - Resident #1 did experience some confusion getting to her room at times. - Resident #1 had been heard to say, "I'm waiting for the children", "looking for my boys" or "I'm waiting for a ride home". - Resident #1 was known to go off the front porch because she was "looking for my children, "Sug". - Resident #1 had been confused. . - Resident #1 was easily redirected and staff never pictured her walking off. - Resident #1 was good about telling staff where she was going, she'd tell staff she was going to sit on the porch or if she was going to the bathroom. - There was always staff at the front desk and checks were performed on all resident rooms every two hours. Interview on 2/23/17 at 4:45 pm with the Resident Care Coordinator (RCC) revealed: - Resident #1 used her rollator, to assist with mobility, and went to activity programs between 2 pm and 3 pm in the afternoons. - The resident would usually come by the RCC's hall office after a program to talk a little. - The resident would then go to sit in her favorite chair, just down from the RCC's office, in the front lobby, facing the front door. - The resident would usually sit there for a couple of hours and then go into the dining room behind the lobby for dinner; she did not go outside to sit. - The last time she saw Resident #1 was on the afternoon of 2/20/17. - The resident stopped by the RCC's office a little after 3:00 pm on 2/20/17 to say hello.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 56 - The resident left the RCC's office to sit in the lobby. - Between 3:45 pm and 4:00 pm, a staff stopped by the RCC's office to inform her Resident #1 was not in the facility and a search was in process to locate the resident. 5. Observation on 2/23/17 at 8:05 am of the facility front door and lobby revealed: - Upon entering the facility, the front door was unlocked, no alarm sounded as the door was opened. - The lobby was empty, there was no staff at the front desk. - There were no staff visible in the facility hallways. - At 8:08 am, the Dietary Mmanager (DM) came out of the dining room into the lobby. Interview on 2/23/17 at 8:10 am with the DM revealed there was no front desk staff until 9 am in the mornings. Interview on 2/23/17 at 8:11 am with a Personal Care Aide (PCA) on the 200 hall revealed: - The staff stated she did not know what time the front door was unlocked, it did not alarm. - There were 3 PCAs and 1 medication aide (MA) working in the assisted living this morning. Observation on 2/23/17 at 8:28 am of the front lobby revealed: - There was no staff at the front desk, no staff at the front entry way. - A resident, using a rollator, came out of the dining room, headed to the front door, pushed the handicapped door release on the wall, went out the door to the front porch. - No alarm had sounded as the door automatically opened.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 57 Interview on 2/23/17 at 8:29 am with the resident on the front porch revealed: - She routinely came out on the front porch after breakfast to smoke. - The front door was always unlocked. - No alarm ever went off when she came outside. Observation on 2/23/17 at 8:38 am of the front door and lobby revealed: - The 1st resident who went outside to smoke pushed the outside door release, entered the building and went down a hallway. - There was no staff at the front desk, no staff at the front entry way. Observation on 2/23/17 at 8:48 am of the front desk and entryway revealed: - There was no staff at the front desk, no staff at the front entry way. - A 3rd resident using a rollator came to sit in a chair in the lobby that faced the front door. - At 8:49, a 4th resident with a walker, came into the front center entryway, about 4 feet away from the front door, paused for 1 minute looking out the front door, then turned around and walked on down the hall. Observation on 2/23/17 at 8:55 am of the front lobby area revealed the Executive Director (ED) arrived and opened the front door; the door was not locked and did not alarm. Interview on 2/23/17 at 8:56 am with the ED revealed: - The front desk staff came in at 9:00 am. - Last night (2/22/17) she set the front door to lock at 6 pm and to unlock at 9:00 am. - The ED was not aware the door was unlocked this morning.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 58 - The door should have stayed locked until 9 am this morning until I came in. - The Business Office Coordinator (BOC) was at the front desk (her office) from 9 am to 5:30 pm. - The ED would check with staff to see what happened, why the door was unlocked. - The door would not alarm if the wander control system was not activated. - The wander control system had not been activated in a while, she did not remember how long. - No residents had been using a wander guard. - The door would not alarm when opened. Interview with 2nd shift Medication Aide (MA) on 2/24/17 at 3:45 pm revealed: - MA was working on 11/5/16 and observed Resident #1 outside. - MA was working on the medication cart and between 4-5 she saw Resident #1 outside walking down the sidewalk and she told MA she was looking for her car and the MA told her that her family member had her car and she came back in the facility. - MA stated around 30 minutes later she saw Resident #1 outside the facility again and was redirected back in the facility. - MA stated Resident #1 was confused and often couldn't find her room and had to be directed by staff. - MA stated Resident #1's confusion has gotten worse over the past year. - There was no change in the level of supervision for Resident #1 after the November incident. Telephone interview with Resident #1's family member on 2/24/17 at 8:42 am revealed: - The family member was notified by the Resident Care Coordinator (RCC) that Resident #1 was missing on 2/24/17 before 5:00 pm.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 59 - Resident #1 had problems with confusion for years. - A previous incident occurred on 11/20/16 (exact time unknown) when the resident was found in the facility parking lot twice and had to be redirected back into the facility. - The family member stated after the November 2016 incident, no one from the facility spoke with them about putting a plan of supervision in place for the resident, or spoke to them about moving Resident #1 to the memory care unit. - The family member stated family visited on Sundays and his concern was the facility did not always have someone sitting at the desk by the front door where residents sit and there was no alarm on the front door or video cameras at the facility. Interview with the ED at the facility on 2/23/17 at 11:55 am revealed: - Resident #1 had dementia and couldn't remember staff names and she called everyone, "Sug". - Resident #1's normal routine was to participate in activities and sit in the front lobby between meal times and activities. - Resident #1 was not displaying any behaviors and no recent incidents of wandering or exit seeking behaviors. - In November 2016, Resident #1 was found in the facility parking lot looking for her car but was redirected back into the building twice. There were no further incidents. - ED stated there was no plan of supervision put in place after the November 2016 incident. - ED stated staff never brought any concerns regarding Resident #1 to her attention in the daily stand up meetings or collaborative care meetings which are held every 2 weeks.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 60 Interview with ED at the facility on 2/23/17 at 4:20 pm revealed: -The facility did not complete an incident report on 11/5/16 because there was no incident, Resident #1 was not injured. Interview with the District Director of Clinical Services (DDCS) on 02/23/17 at 11:30 a.m. revealed: - Per corporate policy, the HWD or RCC or Supervisor on duty were responsible for reporting elopement incidents to her. - They did not report the elopement incident in November 2016 when Resident #1 was found in the parking lot. - It should have been reported to her when the incident occurred. - A resident with an incident of exit-seeking behavior should be monitored every 30 minutes for 24 hours after the incident, then every 1 hour for 24 hours, then every 2 hours for 24 hours. Interview with ED at the facility on 2/27/17 at 9:57am revealed the ED could not find a facility policy on supervision. Interview with ED at the facility on 2/27/17 at 9:59 am revealed: - The facility has a wander control system policy which may be utilized for a resident who is assessed to be at risk for "wandering" outside the community. - Resident #1 was never assessed for a wander guard. Telephone interview with ED on 2/27/17 at 3:09 pm revealed: - ED stated the personalized service assessments are individualized based on each resident's needs.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 61 - ED stated her staff does meal checks and night checks on the residents. 2. Review of Resident #2's current FL-2 dated 04/26/16 revealed: -The resident's diagnoses included senile dementia, depressive disorder, atrial fibrillation, abnormal glucose, hematuria, calculus of kidney, and acute myocardial infarction of the anterolateral wall. -The resident was intermittently disoriented. -The resident was ambulatory. Review of Resident #2's Resident Register signed on 06/26/14 revealed: -The resident was admitted to the facility on 06/30/14. -The resident was forgetful and needed reminders. Review of Resident #2's personal service plan dated 02/14/17 revealed: -The resident did not require assistance with dressing and grooming. -The resident needed reminders at times to take a shower or change clothes. -The resident was independent going to and from the dining room or community activities. -The resident walked around the "community" at least 3 times daily. -The resident liked to walk daily and sometimes needed to be reminded to sign out. -The resident's family member visited multiple times per week and reinforced the need for the resident to sign out. -The resident becomes very anxious, tearful, and depressed over family member not taking him to his house to live and work on the farm. -The resident had memory loss or cognitive	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 62	D 270		

impairment but did not need assistance to accomplish or participate in daily routines due to memory loss or cognitive impairment.
-The resident did not engage in wandering requiring redirection.

Interview and observation of Resident #2 on 02/22/17 at 2:15 p.m. revealed:
-Resident #2 was in his room searching through the closet.
-He was looking for his gloves and he could not remember where he put them.
-He sat on the bed after looking in the closet and on other furniture in his room.
-The resident took off a ball cap and sweat was beaded on his forehead.
-The resident stated he had lived at the facility for about one month (admission date was 06/30/14).
-The resident stated his parents would sometimes take him on trips out of the facility or he would go out by himself because his father had a job during the day.
-The front door of the facility was usually unlocked and he would go outside whenever he wanted.
-The rollator walker in his room belonged to him and he had it as a back-up but he could walk independently.
-The resident stated his father bought the walker for Resident #1 to use when he got older.
-He had not had any falls that he could recall.

Review of Resident Log notes for Resident #2 revealed:
-On 03/30/16 (no time): the resident was very confused tonight.
-On 04/01/16 (2:00 a.m.): the resident was very confused and having crying spells due to the confusion and the resident asked what was wrong with him.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 63 -On 04/07/16 (10:30 a.m.): the resident was very confused, disoriented, and having crying spells. -On 05/21/16 (2:00 a.m.): the resident was up at 1:30 a.m. and he was very upset and confused. Review a Resident Log note dated 11/09/16 at 1:45 p.m. for Resident #2 revealed: -Resident #2 stated in a loud voice that he wanted his pajamas so he could go to bed. -Resident #2 stated they took his pajamas to wash and they were not back yet. -Staff explained to the resident that it was only 2:00 p.m. and he still had to eat supper and he could lay on his bed until suppertime. Review a Resident Log note dated 11/16/16 at 4:00 p.m. for Resident #2 revealed: -Resident #2 went to the doctor today and memory loss was consistent with dementia. -The resident was to continue taking Aricept (for Alzheimer's dementia) and to start Namenda (for Alzheimer's dementia). Review a Resident Log note dated 11/17/16 at 3:46 p.m. for Resident #2 revealed: -Resident #2 was very agitated, upset about television (TV). -The television was working fine. -The resident threw the TV remote on his bed and he was not sure what to do. -The resident turned the TV off and went walking down the hall. Review a Resident Log note dated 11/20/16 (7 - 3 shift) for Resident #2 revealed: -Resident #2 went on a leave of absence to church. -Resident #2 left church and was walking on Highway 17 by himself. -Family was made aware.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 64 Review a Resident Log note dated 01/08/17 (no time) for Resident #2 revealed: -Resident #2 was insistent to go outside multiple times and was asked to stay on the porch because everything was ice. -The resident would continue to go out and he went out two times within an hour and fell both times. -The resident had a bruise to right elbow and an open area on right palm of hand. -The area was cleaned and a bandage was applied. Review of a faxed note to the Physician A for Resident #2 dated 01/08/17 revealed: -The RCC noted Resident #2 had been reminded not to go into the parking lot today. -The resident went out anyway with 1 unwitnessed fall and 1 witnessed fall. -The resident's vital signs were within normal limits and he had a bruise to the right elbow and an abrasion to the right hand. -The hand was cleaned and a bandage applied. -Physician A signed the form but made no comments. Interview with a personal care aide (PCA) on 02/22/17 at 2:50 p.m. revealed: -Resident #2 was confused but he went on walks outside all of the time. -Resident #2 would come back to the facility after he walked. -Staff "just have to keep watching" Resident #2 because of his confusion. Interview with a medication aide (MA) on 02/22/17 at 5:05 p.m. revealed: -Resident #2 was confused and forgetful. -Resident #2 left the facility by himself all of the	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 65 time. -Resident #2 walked all around the facility and in the back of the facility. -Resident #2 walked down one end of the street to a physician's office and to the other end of the street to a friend's house. -Resident #2 walked every day and he was usually gone about 10 to 15 minutes each time he left. -If Resident #2 were to be gone longer than 30 minutes, it would concern her because he was confused "most of the time". -"So far" Resident #2 had come back to the facility on his own. Interview with the Administrator on 02/22/17 at 5:45 p.m. revealed: -Resident #2 had some dementia but he was usually fine during the day. -Resident #2 would get anxious at night because he did not know what he was supposed to be doing. -Resident #2 referred to his son as his father. -Resident #2 had a friend who lived "about 1/8th" of a mile from the facility and the resident would walk to his friend's house by himself. -Resident #2 would walk down the street to a local physician's office, which was the next building over from the facility. -The facility had quite a few residents who routinely walked to the physician's office down the street as their walking route. -Resident #2 did not sign out and they would have to remind him to sign out. -A volunteer would pick up Resident #2 and other residents on Sunday to go to a local church. -In November 2016, Resident #2 left the church without telling anyone and walked back toward the facility. -A church member saw him walking back toward	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 66 the facility near a local restaurant and brought him back to the facility. -The restaurant was about 1/4th mile from the church. -Now the volunteer knew to sit with Resident #2 at church because of concern that he may leave by himself again. -She talked with the family after the incident and they said Resident #2 enjoyed walking. -Resident #2 had never shown that he did not know where he was or where he lived to her knowledge. -Resident #2 always came back to the facility from his walks. -On 01/08/17, there was an ice storm and the facility did not have any ice melt. -Resident #2 liked to walk so he kept trying to go outside to walk when the parking lot had ice on it and he fell. -She was not sure if any supervision was put in place to prevent the resident from going outside when the parking lot had ice on it. Interview with a second MA on 02/23/17 at 4:49 p.m. revealed: -Resident #2 would forget what time of day it is and he would forget that he had eaten supper. -She had spent over 45 minutes one day trying to explain to Resident #2 that he had already eaten supper. -Resident #2 would sometimes get up 2 or 3 times during the night. -Resident #2 had tried to go out the front door a few times around 3am or 4am but she stopped him. -Resident #2 could find his room most of the time but she had to show him where his room was located a couple of times. -Resident #2 would call his friend during all hours of the early morning.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 67 -Resident #2 would go out on the front porch and he would go for walks. Interview with a third MA on 02/24/17 at 1:27 p.m. revealed: -On 01/08/17, Resident #2 went outside and stepped on the ice and fell twice but he did not get hurt. -She did not know if he was being supervised when he went outside and fell on the ice. -Resident #2 was confused occasionally. -She noticed when Resident #2 went out and stayed with his family for a couple of weeks, he would be confused when he came back to the facility. Interview with a fourth MA on 02/27/17 revealed: -Resident #2 had some dementia. -She was working in November 2016 when Resident #2 left the church. -The volunteer reported it to staff at the front desk, then it was reported to her. -She contacted facility management and notified the resident's family member. -She did not notify the physician and she did not know if anyone else notified the physician. -She told staff to keep an eye on Resident #2 when he got back because she was concerned that he may try to leave the facility. -She tried to watch Resident #2 when he went outside on the porch. -Resident #2 sometimes went off the premises when he walked. -Resident #2 sometimes walked to a friend's house that lived up the street from the facility. -She had not known the resident to wander. -Resident #2 would sometimes repeat himself. -Resident #2 knew where his room was in the facility and he knew how to call his family member.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 68 Interviews with a volunteer on 02/23/17 at 5:03 p.m. and 02/27/17 at 9:54 a.m. revealed: -She currently took Resident #2 and two other residents to a local church on Sundays. -The church was about ½ mile from the facility. -For the most part, Resident #2 seemed very lucid. -She had been taking the residents to church for about 2 years. -Resident #2 was familiar with the lay of the layout of the church and he would sometimes go to the bathroom by himself. -She never had any reason to think he would leave on his own. -On 11/20/16, she could not find Resident #2 in the church after the service and it was "major panic". -Another church member found Resident #2 walking on Highway 17 in the direction of the facility. -Resident #2 was walking along the edge of the road (no sidewalk) in front of a restaurant that was about halfway between the church and the facility. -The church member picked up Resident #2 and took him back to the facility. -She was concerned about the danger of Resident #2 walking so close to the traffic. -She notified the facility and the resident's family. -The Administrator told her if it happened again, she did not want him to go to church again. -Since the incident, Resident #2 still went to church with her every Sunday but she made sure they sat on the same pew and she did not let him out of her sight. -A few weeks before the incident on 11/20/16, another resident that went to church with them had passed away and the volunterr noticed that Resident #2 did not understand why the resident	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 69 did not go with them to church any more. -She had explained to Resident #2 that the other resident had passed and would not be coming any more but Resident #2 continued to ask why the resident did not come to church any more. -That was the first time she realized Resident #2 may have some confusion. -She had no idea that Resident #2 would leave church on his own. -The facility staff had not shared any concerns with her about Resident #2's cognitive status. Interview with the District Director of Clinical Services (DDCS) on 02/23/17 at 11:30 a.m. revealed: -According to Resident #2's most current assessment and care plan, he had cognitive impairment but he did not require redirection. -Resident #2 would walk to a friend's house in the neighborhood but he did not wander. -The HWD or RCC or Supervisor on duty were responsible for reporting elopement incidents to her. -They did not report the incident in November 2016 when Resident #2 left church during an outing and was found walking on Highway 17 toward the facility. -It should have been reported to her. -She found out about the incident on the evening of 02/22/17 when she was notified by the facility about a plan of protection being needed. -The Administrator talked with Resident #2s' family member today and they were going to contact the physician about moving the resident the locked special care unit. Interview with the DDCS on 02/23/17 at 12:50 p.m. revealed: -They requested a wander guard bracelet from a sister facility today and are ordering more	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 70 bracelets today. -They should get the wander guard bracelet from the sister facility today and they planned to use it for Resident #2. Observation of Resident #2's room on 02/23/17 at 1:05 p.m. revealed the resident was not in the room. Observation of the 100 hallway, the dining room, the living room near front door, and the lobby area from 1:06 p.m. - 1:08 p.m. revealed Resident #2 was not in either of these common areas. Review of the Resident Sign Out Log on 02/23/17 at 1:08 p.m. revealed Resident #2 had not been signed out of the facility. Interview with the Business Office Coordinator (BOC) on 02/23/17 at 1:10 p.m. revealed: -She was not at the front desk from 12:29 p.m. - 12:59 p.m. due to being on her lunch break. -The Activity Director covered the front desk for the BOC while she was at lunch today. -She had not seen Resident #2 go outside while she was at the front desk. -She was not aware of him leaving the facility with anyone or signing out while she was at the desk. -She did not know the current whereabouts of Resident #2. -She would try to find out where Resident #2 was located. Observation on 02/23/17 at 1:15 p.m. from the parlor on the 200 hall of the facility revealed: -Resident #2 was walking around in the grass behind the facility. -Resident #2 walked into an opening into the woods between some trees and disappeared into	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 71 the woods. -Resident #2 was walking independently without a walker. -Resident #2 was alone and no staff were visible. Interview with the Administrator on 02/23/17 at 1:16 p.m. revealed: -When the surveyor reported the location of Resident #2, the Administrator was not aware Resident #2 had gone outside of the facility without supervision. -She was not aware Resident #2 would walk into the woods behind the facility. -Staff would get him immediately. Observation on 02/23/17 at 1:20 p.m. revealed: -A staff person walked to the front porch with Resident #2 from the right side of the parking lot. -They stopped on the front porch and facility staff were talking with Resident #2. -The Administrator came back inside the facility after staff had redirected Resident #2 to the front porch Interview with the Administrator on 02/23/17 at 1:23 p.m. revealed: -She talked with Resident #2 when he returned to the porch with staff. -Resident #2 told the Administrator that he did not know he had to sign out to walk around the premises. Interview with the Activities Director on 02/23/17 revealed: -She sat at the front desk while the BOM was at lunch today. -She saw Resident #2 go outside to the front porch a couple of minutes prior (around 12:57 p.m.) to the BOM returning from lunch. -That was Resident #2's normal routine.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 72 -She was not aware that Resident #2 should not go outside unsupervised. Observation on 02/23/17 at 3:15 p.m. of the back and right side grounds areas of the facility where Resident #2 had walked into the wood unsupervised revealed: - The back of the facility had a flat, thick, grassy area about 50' between the building and the woods - On the right side of the facility (visible from the conference room/screened-in porch) was a 4' to 6' wide drainage ditch with 2' sloping sides and containing water at various depths from a few inches to the top of the 2' sides. - The drainage ditch ran from the side at the front parking lot of the facility to the adjacent property at the back right of the facility. - The facility side of the drainage ditch was open area with cut grass up to 2' of the edge of the ditch. - The other side of the ditch was wooded, broken limbs of trees and small rocks lay scattered across the ditch in several areas. - There was an 8' wide cleared opening between the woods and the woody upper section of the drainage ditch behind the facility on the right. - From the facility the opening looked like a path into the woods. - Beyond the opening were woods on the left, a large development of high rise apartments located 50 yards ahead and to the right. - A large pond, 60 yards long x 20 yards wide was situated between the apartment buildings and the right side woods where the drainage ditch curved to the right. - The pond had no distinct top edges, the wet, muddy ground sloped about 6' into the water's edge. - The ground around the wet area was slippery.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 73 Interview with the Health and Wellness Director (HWD) on 02/23/17 at 5:30 p.m. revealed: -Resident #2 was oriented to self but he was forgetful. -Resident #2 would forget days of the week or he would forget that he had talked with a family member. -Resident #2 would get tearful and wanted to go home with his family to work on the farm. -Resident #2 would ask why his family member had not come to pick him up. -Resident #2 needed reminders for bathing and probably set up. -She felt Resident #2 was safe to go out into the community on his own but as with anyone there was a concern that he could get hit by a car. -She was not aware Resident #2 referred to his son as his father. Interview with the Resident Care Coordinator (RCC) on 02/23/17 at 5:40 p.m. revealed: -Resident #2 could be "sharp as a tack" one moment but then could not remember what day to put his laundry out or which buttons to press on the television remote control. -Resident #2 would get frustrated and anxious and he would say, "What am I supposed to do?" -She reviewed shift reports daily and she recalled seeing some notes documented by staff about the resident's anxiety. -Resident #2 walked outside by himself frequently depending on the weather. -Resident #2 walked to a friend's house down the street from the facility. -The road in front of the facility "scares" her because there was no sidewalk and there was a curve in the road. -The resident had to walk on the edge of the road to go to his friend's house since there was not	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 74 sidewalk and she was concerned a car may come speeding down the road around the curve and not see the resident in time to stop. -Resident #2 walked around the facility but he would not go into the woods. Interview with the RCC on 02/27/17 at 11:01 a.m. revealed: -On 01/08/17, there was an ice storm and they had ice in the parking lot. -She was outside putting out ice melt in the parking lot. -Resident #2 came outside because he wanted to help but she told the resident not to go off of the porch because there was ice in the parking lot. -She turned her back to put down the ice melt and Resident #2 fell in the parking lot because he was trying to come and help her. -The resident had a laceration on one of his wrists and she cleaned and bandaged it. -She ran out of ice melt and had to go to a local hardware store to buy some more. -She told staff on duty she as leaving the facility to get more ice melt. -They were aware she had left and that Resident #2 had fallen earlier in the parking lot. -She was not aware of any supervision put in place to prevent Resident #2 from going back outside to the parking lot. -When she returned to the facility a few minutes later, she saw Resident #2 walking on the ice in the parking lot alone. -Before she could get to him, he fell on the ice again. -The bandage from the first fall came off but there were no other injuries noted. Interview with the Administrator on 02/23/17 at 6:05 p.m. revealed: -They had received the wander guard bracelet	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 75 from the sister facility. -Resident #2 and the DDCS were in the Administrator's office currently and the DDCS was showing the bracelet to the resident and explaining how it worked. Observation on 02/23/17 at 7:00 p.m. revealed Resident #2 was in the lobby area and he was wearing a wander guard bracelet. Review of a letter faxed to the facility from Physician A for Resident #2 on 02/23/17 revealed: -Resident #2 had never been a wanderer. -When living with the resident's family, there had been no problems. -After discussing with family member today, the family felt there was no problem with wandering. -Resident #2 had either mild dementia or pseudobulbar affect from cerebral vascular disease. -Therefore, to walk outside of the facility at this time is of no concern. -If more information was needed, the physician noted to call him. Interview with the Administrator on 02/23/17 at 4:05 p.m. revealed: -She asked Physician A if he felt Resident #2 was at risk for elopement or wandering. -Physician A told the Administrator there had been improvement with new medications for the resident in the last 18 months. -She did not tell Physician A about the incident in November 2016 when Resident #2 left a local church without supervision and was found walking down Highway 17 toward the facility. -She could not recall if she told Physician A that Resident #2 would refer to his son as his father. Interview with Physician A for Resident #2 on	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 76 02/24/17 at 8:30 a.m. revealed: -He had not seen Resident #2 for a medical visit since September 2016. -Resident #2 used to live with a family member and the family member said the resident walked and enjoyed being outside. -Resident #2 had some mild dementia. -Resident #2 seemed "pretty much with it" in regards to surroundings. -Resident #2 may also have some vascular dementia. -Resident #2 had pseudobulbar affect with a lot of crying spells that he started a new medication to treat it last year. -He did not have any record of the incident in November 2016 when Resident #2 left a local church unsupervised and was found walking down Highway 17 toward the facility. -He was not aware of the incident. -The facility had not reported any concerns about the resident being forgetful or confused. -He thought since the resident had some forgetfulness and confusion, it would be good to use a wander guard bracelet for the resident. Review of an order from Physician A dated 02/24/17 revealed: -The physician wrote an order for wander guard (to prevent wandering). -The physician wrote the resident had dementia or pseudobulbar affect. -The wander guard was for prophylactic or prevention. Review of a letter faxed to the facility from Physician B's office for Resident #2 on 02/27/17 revealed due to the resident's diagnoses of dementia, the resident required "an attendant at all times on and off of Brookdale property".	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 77 Interview with Resident #2's family member on 02/23/17 at 7:40 p.m. revealed: -Resident #2 had lived at the facility since 2014. -He visited the resident 2 to 3 times a week. -Resident #2 had a bit of dementia and some days he was forgetful. -Resident #2 sometimes thought this family member was his brother but he was not the resident's brother. -Resident #2 did not remember how long he had lived at the facility. -He was aware Resident #2 would take walks outside of the facility. -He was aware Resident #2 would walk to a friend's house up the street from the facility. -Resident #2 managed to walk up the street and back to the facility. -He did not think Resident #2 would depart from the main street. -He was notified by the facility about the resident leaving church in November 2016. -He thought the resident got impatient and left. -Resident #2 got emotional and had crying spells when the resident thought of his wife who was deceased. -The Administrator talked with him about using the wander guard bracelet for Resident #2 today and doing "buddy" walks. -He was in agreement with whatever it took to keep Resident #2 safe. 3. Review of Resident #9's current FL2 dated 8/12/16 revealed: -Her diagnoses included senile dementia uncomplicated, neurohyphosis, and tachycardia. -Resident #9 was described as ambulatory, and intermittently disoriented. Review of the Resident Register for Resident #9 revealed he was admitted to the facility on 2/4/14.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 78 Review of the Licensed Health Professional Support evaluation dated 1/18/17 for Resident #9 revealed: -Resident #9 was described in the Health Status Review as being alert with some short term and long term memory deficits. -Resident #9 was "pleasantly confused per normal". Observation of the exit door at the end of the 300 hallway revealed: -The door was locked with a key pad. -The door alarmed when pushed, the door also opened when pushed for 15 seconds or longer. -The door alarm sounded until it was manually disarmed. Interview with a Personal Care Aide (PCA) on 2/24/17 at 12:55pm revealed: -As she was walking through the facility hallway and passed by the front lobby, she spotted Resident #9 out on the front porch unaccompanied. -The resident was attempting to walk off the porch when she walked over and redirected the resident back into the facility. -She was concerned when she saw the resident walking off of the porch that day, because she did not think the resident could go walking and remember how to come back to the facility. -The door was not set to alarm and there was no staff person stationed in the lobby. -She could not recall the date of the incident, but she did recall that it was warm outside during that time. -She reported the incident to the supervisor that day, but could not recall who that was. -Resident #9 was confused sometimes, "when she was having a bad week, she just cannot get	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 79	D 270		

right for a couple of days in the week".
-Resident #9 would sit in the lobby "when she was not sure where her room was".
-She was not sure what happened that day, because Resident #9 usually, "just sat in the lobby, was not exit seeking, and did not talk about going anyplace".

Interview with a second PCA on 2/24/17 at 3:41pm revealed:
-On 2 occasions she had seen Resident #9 go out of the exit door in the 300 hallway, which opens up to the back parking lot. Each time, the door alarm sounded and the resident had to be redirected back into the facility by staff.
-There was an incident in 2016 before Thanksgiving (she could not recall the date), when Resident #9 went out the exit door in the 300 hallway and got as far as the sidewalk in the back near the parking lot. The Administrator caught the resident out there that day and brought her back inside.
-Resident #9 sat on the porch regularly, she had not been told Resident #9 could not sit out on the porch.
-Usually when Resident #9 went out on the porch there were other residents out there also, with no staff present
-She had never seen Resident #9 sit out on the porch alone.

Interview with a MA on 2/24/17 at 3:55pm revealed:
-Resident #9 had been allowed to go out on the porch and sit in the rocker, without staff. She had never been told the resident could not sit on the porch.
-Resident #9 was confused most of the time and would be looking for her truck.
-On 2/23/17 she was asked by management,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 80 which resident she thought might be at risk for elopement and she named Resident #9. -A couple of times Resident #9 had been caught further than the porch, she had gotten on the sidewalk and the right side of the building and was walking along approaching the side of the building. -She could not recall the dates of these incidents, but did not feel Resident #9 was safe, outside unsupervised. Review of the Resident Log for Resident #9 revealed: -On 8/10/16 at 5:45pm the resident said she was going outside to look for her mother. The resident went down the 300 hall to the exit door and set off the alarm. Resident #9 did not exit the door, she was redirected to the dining room. -The resident's family was called, the family member said the resident did that at times. The residents' family member went to the facility at 6:00pm, and there were no further issues that day. -On 9/16/16 Resident #9 was found in the back parking lot of the facility, by the Maintenance Director around 5:00pm. The resident was wandering around in the parking lot by herself. -The Maintenance Director called into the facility and spoke with a Medication Aide (MA). -The MA went outside and redirected the resident back into the facility. -The MA immediately notified the Administrator and the resident's family. The Health and Wellness Director was later notified. -On 11/5/16 between 7:00am and 3:00pm, Resident #9 was found at the end of the 300 hallway trying to leave out the exit door. The resident was redirected -After being redirected, Resident #9 went out of the front door.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 81 -As Resident #9 was walking outside her family member walked up and "took her out for a while". -On 2/12/17 facility staff walked into Resident #9's room and she was packing up the photos in her room. The resident said she was "going to head home", staff redirected the resident. -Resident #9 was walking around the hallway around lunchtime asking "how do we get out of here". -2/14/17 between 7:00am and 3:00pm, Resident #9 was "exit seeking on the end of the 300 hallway". Interview with the Health and Wellness Director on 2/27/17 at 12:50pm revealed: -When residents were identified as wanderers or exit seeking, the facility would set up a meeting with the family, and consult with the physician to discuss options. -There was one occasion of Resident #9 being in the front of the building walking down to the end of the sidewalk. -The resident's family was notified and came to the facility and sat with the resident. -She had not been informed of Resident #9 having any exit seeking behaviors. -Resident #9 was" not exit seeking, she was not a wanderer". Interview with Resident #9's physician office on 2/27/17 at 10:07am revealed: -Resident #9 had been diagnosed with dementia "some time ago," that was not a new diagnosis. -Resident #9 could not be expected to remember anything. -There would be concern if Resident #9 was outside walking alone, she could not be expected to make it back to the facility, on her own. Interview with the Administrator on 2/27/17 at	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 82 3:00pm revealed: -Resident #9 had been confused since she was admitted in 2014. -The staff had not been concerned Resident #9 would walk off, prior to last week. -Resident #9 sat out on the porch frequently with a small group of residents. The resident had gone out alone a couple of times, she was not sure if Resident #9 would know to come back. -She was aware of a couple of incidents where Resident #9 had wandered beyond the porch of the facility and had to be redirected back into the facility by staff. The resident's family was called and the family member went to the facility and sat with the resident. -Resident #9 had "never gotten off the property". -She was aware of an incident back in September 2016, when Resident #9 walked out the front door of the facility, along the sidewalk of the facility to the back. -The resident was redirected back into the facility by the Maintenance Director. -She recalled another incident in November or December 2016 when she saw the resident walk outside alone, along the sidewalk near the screened in porch, she redirected the resident back into the facility. -She could not recall the exact dates or times of those incidents. -On February 23, 2017 staff were asked what residents they might be concerned about going outside alone and staff named Resident #9. -As of last week (2/23/17) staff "would be keeping a closer eye" on Resident #9. Resident #9 was placed on a list of residents that would not be allowed outside without staff being present. -As of 2/23/17 Resident #9 was being considered for a wander guard.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 83 -She spoke with a family member of Resident #9 on 2/26/17, and discussed taking Resident #9 to the physician and obtaining a physician order for a wander guard for the resident. --- The facility failed to provide supervision for residents having dementia, confusion, and disorientation, who eloped from the facility. Resident #1, diagnosed with dementia and confusion, resided in the assisted living section, eloped from the facility, unobserved, twice in November 2016. The resident eloped from the facility the late afternoon of 2/20/17, unobserved by staff. Resident #1 was found by police the next day, 2/21/17, deceased, about a half mile from the facility. Resident #2 with a diagnoses of senile dementia was noted to be intermittently-disoriented and had left the facility unsupervised on a daily basis and walked aound the facility, in the woods, and down the street; left a church service unsupervised and was found walking on the edge of a highway about one-quarter of a mile from the facility; and had 2 falls in the parking lot after an ice storm while unsupervised. Resident #9 had dementia, was disoriented, and confused, wandered to the back facility parking lot, and eloped going down the sidewalk past the facility. The failure of the facility to assure supervision of residents resulted in the death of Resident #1 and risk of serious physical harm to Residents #2 and #9 constitutes a Type A1 Violation. --- The Executive Director provided a "Plan of Protection" for all residents effective 2/22/17: - The front door will be locked and alarmed. - All doors will be locked and alarmed immediately. - Staff will do 30 minute checks on (Resident #2)	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 84 until evaluated by physicians. - Care Staff will do check off sheet for 30 minute checks. - Residents with a dementia diagnosis will be evaluated for an elopement risk. - (The) front door will have a staff member at the desk at all times when the front door is not alarmed. -The (front) door is alarmed from 6 pm to 9 am. - Residents will be evaluated on 2/23/17. - Any resident at risk for elopement will be referred to the physician for assessment for memory care placement. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 30, 2017.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility did not meet the health care needs for 1 of 5 residents (#2) sampled by failing to obtain physical therapy / occupational therapy evaluation and treatment for the use of a rollator walker and failing to notify two physicians of the resident's refusal to use the walker. The findings are:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 85 Review of Resident #2's current FL-2 dated 04/26/16 revealed: -The resident's diagnoses included senile dementia, depressive disorder, atrial fibrillation, abnormal glucose, hematuria, calculus of kidney, and acute myocardial infarction of the anterolateral wall. -The resident was intermittently disoriented. -The resident was ambulatory. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 06/30/14. Review of Resident #2's personal service plan dated 02/14/17 revealed: -The resident walked around the community at least 3 times daily. -The nurse documented the resident had not fallen in the past 12 months. -The nurse documented the resident did not use any mobility aids. Observation of Resident #2's room on 02/22/17 at 2:15 p.m. revealed there was a sign on the wall inside the room near the entrance reminding the resident to use his walker. Interview and observation of Resident #2 on 02/22/17 at 2:15 p.m. revealed: -The rollator walker in his room belonged to him and he had it as a back-up but he could walk independently. -The resident stated his father bought the walker for Resident #1 to use when he got older. -He had not had any falls that he could recall. Review of a physician's order dated 09/15/16 from Physician A for Resident #2 revealed there was an order for a rollator walker with seat for	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 86 mobility and to prevent falls. Review of a form faxed to Physician A for Resident #2 dated 09/16/16 revealed: -The Health and Wellness Director (HWD) noted the resident was recently ordered a rollator walker and the facility's policy required everyone with a walker have physical therapy / occupational therapy (PT/OT) to show them how to use it. –The HWD asked if they may have an order for PT/OT. -Physician A responded on 09/19/16 with an order for PT/OT for rollator teaching. Review of a Resident Log note dated 09/19/16 for Resident #2 revealed: -The HWD spoke with Resident #2's family member about the need to have a "face-to-face" form signed by the physician with orders for PT/OT to evaluate for safe / appropriate use of walker. -The resident had a physician's appointment on 09/21/16 and the HWD would put a "face-to-face" sheet in the physician's folder with request for PT/OT evaluation for use of walker. Review of a Resident Log note dated 09/20/16 for Resident #2 revealed: -Staff documented "faxed PT/OT order". -Staff did not document who the order was faxed to. Review of a form faxed to Physician B for Resident #2 dated 09/21/16 revealed: -The HWD noted for the physician to sign a face-to-face sheet so the resident's insurance would pay for a walker and for PT/OT to evaluate use of walker. -The HWD asked the physician to order PT/OT to evaluate for walker use.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 87 -Physician B signed the order request form. Review of Resident #2's record revealed there was no documentation that the resident received any PT/OT evaluation or treatment. Interview with a medication aide (MA) on 02/23/17 at 4:49 p.m. revealed: -Resident #2 would go out on the front porch and he would go for walks. -She had never seen Resident #2 use his walker. -Resident #2 was a little unsteady when he first got up in the mornings. Interview with the HWD on 02/23/17 at 5:30 p.m. revealed: -Resident #2 was oriented to self but he was forgetful. -A family member brought the walker for Resident #2. -She was going to get the walker discontinued because the resident said he was never going to use it. -She did not recall if Resident #2 had been evaluated or seen by physical therapy or occupational therapy. Interview with the Resident Care Coordinator (RCC) on 02/23/17 at 5:40 p.m. revealed: -Resident #2 did not ever use his walker. -She did not know if Resident #2 ever had any PT or OT. -Resident #2's family member requested staff to put a sign in the resident's room to remind the resident to use his walker. Interview with the HWD on 02/24/17 at 4:45 p.m. revealed: -There was only 3 home health companies the facility used for PT/OT orders depending on the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 88 family's preference. -She was not sure which home health company Resident #2's PT/OT order was faxed to or why it was not followed up. Interview with a second MA on 02/27/17 revealed: -She faxed the PT/OT order from 09/2016 for Resident #2 to a home health company but she could not recall which one. -She did not know if the resident had received any PT/OT services. -Resident #2 was not using his walker because he could not keep up with it. -Resident #2 walked fine. Interview with the 3 home health companies used by the facility on 02/27/17 revealed: -Neither of the companies could find Resident #2 in their system. -They had not received any orders for PT/OT for Resident #2. -They had never provided PT/OT services to Resident #2. Review of a Resident Log note dated 02/24/17 at 10:50 a.m. for Resident #2 revealed: -The HWD faxed an order request to the physician to discontinue the use of Resident #2's walker due to his refusal to use. -The HWD noted the resident did not ever utilize the walker and continued to refuse to use it. -The resident ambulated independently. Review of a form faxed to Physician A for Resident #2 dated 2/24/17 revealed: -The HWD noted the resident had not utilized the walker and he had continued to refuse to use it. -The HWD asked if they may have an order to discontinue the walker. -Physician A responded on 02/26/17 and signed	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 89 the request to discontinue the walker. Review of a form faxed to Physician A for Resident #2 dated 2/28/17 revealed: -The HWD asked the physician to sign an order to discontinue PT/OT orders for use of walker because resident refused to use walker during ambulation. -There was no response documented by Physician A on the form on 02/28/17. Observation on 02/23/17 at 1:15 p.m. from the parlor on the 200 hall of the facility revealed: -Resident #2 was walking around in the grass behind the facility. -Resident #2 walked into an opening into the woods between some trees and disappeared into the woods. -Resident #2 was walking independently without a walker. Observation of Resident #2 throughout the on-site survey from 02/22/17 - 02/24/17 revealed: -The resident walked to the front lobby area, outside, and back and forth to his room multiple times. -The resident was never observed using a walker. -Staff was never observed reminding or asking the resident to use his walker. -The resident walked independently with no ambulation devices. -The resident had a steady gait at the times observed. Review of an incident report dated 01/08/17 for Resident #2 revealed: -The resident had a witnessed fall in the parking lot on 01/08/17 at 2:30 p.m. -There was no apparent injury. -The incident was witnessed by the RCC.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 90 -The family and physician were notified. Interview with Resident #2's family member on 02/23/17 at 7:40 p.m. revealed: -Resident #2 had lived at the facility since 2014. -He visited the resident 2 to 3 times a week. -Resident #2 had a bit of dementia and some days he was forgetful. -He was aware Resident #2 would take walks outside of the facility. -He and Resident #2 argued about the walker. -Resident #2 needed the walker and there was a sign in his room to remind him to use the walker. -Resident #2 needed right knee replacement but the surgery was too risky so the resident did not walk as steady and he weaved a little bit while walking. -Resident #2 did not remember to use the walker so staff should remind him. -Resident #2 did not have PT or OT for use of the walker to his knowledge. -Physician A was Resident #2's primary care physician. -He took Resident #2 to another physician, Physician B, to have CT scan and blood work because he knew Physician B. -Physician B was letting Physician A know what is going on related to Resident #2's care. Interview with Physician A for Resident #2 on 02/24/17 at 8:30 a.m. revealed: -He had not seen Resident #2 for a medical visit since September 2016. -Resident #2 used to live with a family member and the family member said the resident walked and enjoyed being outside. -Resident #2 had some mild dementia. -Physician A was not aware Resident #2 was seeing another physician and getting orders from another physician.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 91 -He did not recall seeing Resident #2 with an unsteady gait. -He could not recall if he had ordered a walker or PT/OT. Review of a letter faxed to the facility from Physician B's office for Resident #2 on 02/27/17 revealed Resident #2 also needed to use his walker / cane at all times. Interview with the Medical Receptionist for Physician B's office on 02/27/17 at 4:27 p.m. revealed: -Physician B was out of state and unavailable for interview. -She heard back from the physician on Saturday, 02/25/17, and she contacted the facility regarding Resident #2 the same day, 02/25/17. -Physician B texted the following response related to Resident #2, "he is able to leave but not alone, requires attendant and cane or walker". -The physician asked her to type a letter and fax the information to the facility since he was out of state until Wednesday, 03/01/17. -She spoke with a female at the facility to relay the information but she could not recall the name of the person she spoke with on Saturday, 02/25/17. -The person she spoke with asked her to leave out the information about the walker in the letter because the resident was not going to use the walker. -No one had reported to their office that the resident was not using his walker. -She did not included the information about the walker in the letter since the person from the facility told her not to include it. -She would check with Physician B again about the walker.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 92 Interview with the Medical Receptionist for Physician B's office on 02/27/17 at 5:00 p.m. revealed: -Physician B was Resident #2's primary care physician. -She spoke with the Administrator today who had talked with Resident #2's family member. -The family member told the Administrator he took Resident #2 to Physician B for a second opinion and Physician A was the resident's primary care physician. -They were not aware Resident #2 was being seen by another primary physician. -They had seen Resident #2 on multiple occasions including 11/01/16, 11/16/16, and 02/15/17. -Resident #2 had a six months office visit scheduled for 08/01/17. -Physician B's office had not been notified that Resident #2 was not using his walker or that he had not received physical therapy. -The Administrator told her that the facility staff were not sure which physicians' orders to follow for Resident #2 since he had been seeing two different physicians. Interview with the Administrator on 02/28/17 at 9:28 a.m. revealed: -She got a fax from Physician B yesterday regarding Resident #2. -She had a meeting yesterday with Resident #2's family member and the family wanted Physician A to be Resident #2's primary care physician. -She received an order yesterday from Physician A to discontinue Resident #2's walker. -Then she got an order after that from Physician B for Resident #2 to use walker / cane at all times. -She did not know if anyone at the facility had noticed the Resident #2 was being seen by two	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 93 different primary physicians prior to the survey. -She asked the family member to make an appointment for Resident #2 with Physician A so they could start new with his orders and get a new FL-2. -She asked the family member to let Physician B know that Physician A would be Resident #2's primary care physician going forward and Physician B should not send any more orders. -Physician B's order for Resident #2 to use the walker was more current and they would use that order until the resident could be seen by Physician A and evaluated.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to assure daily weights were obtained and documented for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL-2 dated 8/19/16 revealed diagnoses included coronary artery disease, hypertension, dementia and high cholesterol.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 94 Review of a physician order for Resident #3 dated 12/27/16, revealed: -An order for the resident to be weighed daily and the physician to be notified of weight gain or loss of 3-5 lbs in one day. -Lasix 40mg daily for 3 days, then continue 20mg daily. Review of the January 2017 Medication Administration Record (MAR) for Resident #3 revealed: -There was missing documented weight for 9 days in January. -The documented weights were missing for the following dates: 1/2/17, 1/21/17, 1/24/17-1/28/17, 1/30/17, and 1/31/17. -His documented weights 1/3/17 through 1/23/17 varied between 138.6 and 148 lbs. Review of a Physician/ Healthcare Provider Visit Form dated 1/24/17 for Resident #3 revealed -The resident's edema had improved and his Lasix order was changed to eery other day. -Weights were to be obtained daily and the physician wanted to be notified for weight gains greater than 5lbs. Review of the February 2017 MAR for Resident #3 revealed, there were no weights documented for Resident #3 for the month of February. Interview with resident #3's physician office on 2/27/17 at 9:13am revealed: -On 12/27/16 daily weights were ordered for Resident #3, with parameters to inform the physician of 3-5 lb weight changes in either direction. -The facility called the physician to report weights for Resident #3 on the following dates:	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 95 1/6/17, 1/10/17, and 1/16/17. -The last time the facility called the physician to report Resident #3's weight was 1/16/17. -On 2/21/17, Resident #3 was seen in the office for a follow up and a weight was obtained. That was the last documented weight they had on file for Resident #3. -On 2/13/17 the facility staff called the physician office to inquire if they were still required to obtain weights for Resident #3. -On 2/14/17 an was order given to the facility for weights to be obtained biweekly and inform the physician of 3-5 lb. weight change in either direction. -The order was given to staff verbally; the order was not faxed to the facility. -That was the last communication the physician office had with the facility regarding Resident #3. Interview with a Medication Aide on 2/23/17 at 5:25pm revealed: -The Medication Aides were responsible for obtaining daily or biweekly resident weights as ordered by the physician. -The Medication Aide would sometimes delegate that task to the personal care aide. -Weights were usually obtained before breakfast, because there was not a specific time they were required. -The Medication Aides faxed results for Resident #3 to the physician every 3 days. -The resident weight logs were kept in the front of the MAR in the MAR book. -Monthly weights were collected on each resident, kept in a binder and given to the Resident Care Coordinator monthly. Interview with the Resident Care Coordinator on 2/23/17 at 4:33pm and 5:55pm revealed: -She was unable to locate any weights obtained	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 96 in February 2017 for Resident #3. -On 2/14/17, the physician changed the daily weight requirement from daily weights to biweekly weights for Resident #3. -She could not locate the physician order obtained on 2/14/17. -She did not know why or when the facility stopped obtaining daily weights on Resident #3. -The medication aide was responsible for obtaining resident's weight. -She was responsible for obtaining monthly weights on each resident on the 7th of the each month. -She should have been monitoring to ensure the medication aide and supervisor was obtaining and faxing resident's weight, per physician order. -She had been monitoring the record monthly to ensure weights were obtained and documented, for residents with weight orders more frequently than once a month. -She would start monitoring the record daily to ensure the weights were obtained and documented for resident with weight orders more frequently than once a month. Interview with the Health and Wellness Director on 2/27/17 at 12:50pm revealed: -Weight ordered were carried out in accordance to the physician order. -The Medication Aides were responsible for obtaining the resident's weight. -Per policy, the RCC and HWD were responsible for auditing the MAR's once a week to ensure the weights were obtained, and documented per physician order. -As of last week (2/23/17), the RCC and HWD were to start monitoring the MAR daily to ensure weights were obtained. Based on observation, interview, and record	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 97 review Resident #3 was not interviewable.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 6 residents (#6, #7, #8) observed during the medication pass, including errors with a liquid iron supplement, a laxative, a nasal spray for seasonal allergies, a cholesterol medication, a vitamin for Vitamin D deficiency, and a supplement used to lower triglycerides and for 1 of 5 residents (#2) sampled for review including errors with an antipsychotic and a supplement for arthritis. The findings are: 1. The medication error rate was 21% as evidenced by the observation of 6 errors out of 28 opportunities during the 8:00 a.m. medication pass on 02/23/17. A. Review of Resident #8's current FL-2 dated 04/27/16 revealed the resident's diagnoses included Alzheimer's senile dementia, Vitamin D	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 98 deficiency, glaucoma, osteoarthritis, interochanteric fracture of the right hip, fracture of the humerus, and fracture of distal radius ulna. a.) Review of Resident #8's current FL-2 dated 04/27/16 revealed an order for Ferrous Sulfate 325mg twice a day. (Ferrous Sulfate is an iron supplement used to treat anemia.) Review of a subsequent physician's order dated 12/23/16 for Resident #8 revealed: -The facility faxed a request to the physician indicating the resident had been spitting out the iron pills for the last 3 weeks and could they get it in liquid form. -The physician's wrote in the order section of the form to consult with the pharmacy for equal dosing for the liquid Ferrous Sulfate. Review of Resident #8's physician's orders and resident notes revealed no further information regarding the dosage of liquid Ferrous Sulfate to be administered. Review of Resident #8's February 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Ferrous Sulfate Elixir 220mg/5ml take 7ml (308mg) twice a day. -Ferrous Sulfate Elixir was documented as administered at 8:00 a.m. and 8:00 p.m. Observation and interview during the medication pass on 02/23/17 revealed: -The medication aide (MA) poured Ferrous Sulfate 220mg/5ml Elixir into a clear plastic graduated measuring cup. -The medication cup was marked with increments of 2.5, 5, 7.5, 10, 15, 20, 25, and 30mls. -There was no line marking 7mls.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 99 -The MA poured the liquid just below the line marked as 7.5mls. -The MA commented she poured the liquid just below the 7.5ml line because there was no marking on the cup to measure 7mls. -She administered the Ferrous Sulfate Elixir to Resident #8 at 8:55 a.m. Interview with the MA on 02/23/17 at 10:45 a.m. revealed: -There was no measuring device available at the facility to measure 7mls so she estimated the dose just under the 7.5ml line on the medication cup. -She had not contacted the pharmacy to get a device that would accurately measure 7mls. Interview with the Health and Wellness Director (HWD) on 02/23/17 revealed: -Staff needed to use an appropriately marked measuring device to for the Ferrous Sulfate Elixir. -She was not aware staff was estimating the dosage of the Ferrous Sulfate for Resident #8. -There should be a complete order with the physician's signature for the liquid Ferrous Sulfate. Interview with a pharmacy technician from the primary pharmacy on 02/27/17 at 9:06 a.m. revealed: -The pharmacist calculated a dose for the liquid Ferrous Sulfate based on the order for the tablet Ferrous Sulfate 325mg twice a day and the physician's instructions to calculate the dosage. -The Ferrous Sulfate Elixir did not come with a dropper and the facility would have to request a dropper if they needed one. -They dispensed the Ferrous Sulfate Elixir on 01/03/17 in a 473ml bottle.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 100 Interview and observation with a second MA on 02/24/17 at 3:45 p.m. revealed: -She did not see a dropper in the medication cart to use with Resident #8's Ferrous Sulfate Elixir. -She used the measuring cup on the cart to estimate the 7ml dose by measuring just under the 7.5ml line marking on the cup. Interview with the HWD on 02/27/17 at 11:18 a.m. revealed: -She called the pharmacy on Friday to get a measuring device for the Ferrous Sulfate. -It should have been received by today and available for use. -She would check to see if the measuring device had come in. Review of a faxed note dated 02/27/17 at 11:40 a.m. revealed: -The HWD spoke with someone at the pharmacy and they will send 10 oral syringes tonight on 02/27/16 for Resident #8's Ferrous Sulfate Elixir. b.) Review of Resident #8's current FL-2 dated 04/27/16 revealed an order for Flonase Nasal Spray 2 sprays in each nostril (frequency not specified). (Flonase Nasal Spray is used treat symptoms of seasonal allergies.) Review of a signed physician's order sheet dated 01/09/17 revealed an order for Flonase Nasal Spray inhale 2 sprays in each nostril once daily. Review of Resident #8's February 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Flonase Nasal Spray inhale 2 sprays each nostril daily. -Flonase as scheduled to be administered at 8:00 a.m.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 101 Observation of the 8:00 a.m. medication pass on 02/23/17 revealed Flonase Nasal Spray was not administered to Resident #8 when she received her other morning medications at 8:55 a.m. Review of Resident #8's February 2017 MAR on 02/23/17 at 10:10 a.m. revealed Flonase Nasal Spray was not documented as administered on 02/23/17 at 8:00 a.m. Interview with the medication aide (MA) on 02/23/17 at 10:45 a.m. revealed: -She usually gave the Flonase to Resident #8 when she received her other morning medications. -She forgot to administer the Flonase Nasal Spray that morning because she was nervous. Interview with a pharmacy technician from the primary pharmacy on 02/27/17 at 9:06 a.m. revealed: -They dispensed 1 bottle of Flonase Nasal Spray on 09/19/16, 10/21/16, 12/06/16, and 02/20/17. Interview with the Health and Wellness Director (HWD) on 02/23/17 revealed: -MAs were supposed to read the MARs carefully when administering medications to make sure all medications were administered at the appropriate time. -She would notify the physician of the medication error. Based on observation and record review, Resident #8 was not interviewable due to diagnoses of dementia. c.) Review of Resident #8's current FL-2 dated 04/27/16 revealed an order for Miralax 17gm once daily. (Miralax is a laxative.)	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 102 Review of a signed physician's order sheet dated 01/09/17 revealed an order for mix 1 capful (17gm) in 8 ounces of liquid and drink daily. Review of Resident #8's February 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Miralax mix 1 capful (17gm) in 8 ounces of liquid and drink daily. -Miralax was scheduled to be administered at 8:00 a.m. Observation of the 8:00 a.m. medication pass on 02/23/17 revealed Miralax was not administered to Resident #8 when she received her other morning medications at 8:55 a.m. Review of Resident #8's February 2017 MAR on 02/23/17 at 10:10 a.m. revealed Miralax was not documented as administered on 02/23/17 at 8:00 a.m. Interview with the medication aide (MA) on 02/23/17 at 10:45 a.m. revealed: -The third shift MA usually gave Miralax to Resident #8 when they got her up in the mornings because the resident was thirsty in the mornings. -That was how she did the Miralax when she worked on third shift. -The MA usually initialed the MAR because she thought the third shift MA administered the Miralax but she forgot to initial the MAR today. -The resident had regular bowel movements and was not having any current issues with constipation. Interview with a pharmacy technician from the primary pharmacy on 02/27/17 at 9:06 a.m. revealed they dispensed 1 bottle (527 grams) of	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 103 Miralax on 09/22/16, 11/01/16, 12/18/16, 01/20/17, and 02/17/17. Interview with the Health and Wellness Director (HWD) on 02/23/17 at 11:55 a.m. revealed: -MAs were supposed to read the MARs carefully when administering medications to make sure all medications were administered at the appropriate time. -Third shift staff would not administer medications scheduled for 8:00 a.m. -She would notify the physician of the medication error. Interview with a third shift MA on 02/23/17 at 4:49 p.m. revealed: -She worked last night on the 11pm - 7am shift as a medication aide in the special care unit. -She did not administer Miralax to Resident #8. -She only administered a cream to Resident #8 because it was scheduled at 6:00 a.m., during her shift. Based on observation and record review, Resident #8 was not interviewable due to diagnoses of dementia. B. Review of Resident #7's current FL-2 dated 09/28/16 revealed the resident's diagnoses included Parkinson's disease, gait disturbance, mood disturbance, and personal stress. a.) Review of Resident #7's current FL-2 dated 09/28/16 revealed there was an order for Fish Oil 500mg 1 by mouth once a day. (Fish Oil is a supplement used to lower triglycerides.) Review of Resident #7's February 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Fish Oil	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 104 500mg take 1 capsule daily and it was scheduled to be administered at 8:00 a.m. -Fish Oil 500mg was documented as administered daily from 02/01/17 - 02/23/17. Observation of the medication pass on 02/23/17 revealed Resident #7 was administered one Fish Oil 1000mg capsule at 8:31 a.m. instead of 500mg as ordered. Review of medications on hand for Resident #7 revealed: -There was an over-the-counter bottle of Fish Oil 1000mg capsules with no pharmacy label. -There was no Fish Oil 500mg capsules on hand for the resident. Review of a resident log note for Resident #7 dated 01/19/17 revealed the facility's RN noted the resident's son called to inform that he wanted all over-the-counter medications for Resident #7 to be ordered through the facility's primary pharmacy. Interview with the medication aide (MA) on 02/23/17 at 1:55 p.m. revealed: -She gave the Fish Oil 1000mg capsule because that was the supply the resident's family had brought to the facility. -She had not noticed the entry on the MAR was for Fish Oil 500mg. -When they got medications from residents' families, the MAs were supposed to compare the medications brought in with the medication orders on the FL-2. -She did not know if anyone checked Resident #7's medications when they were brought by the family. -She was not aware the resident's Fish Oil was now supposed to be ordered through the primary	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 105 pharmacy. -They were probably just using up the supply the family had brought. Interview with Resident #7 on 02/24/17 at 3:55 p.m. revealed: -Most of his medications came from a mail order pharmacy. -His family member helped with his medications. -His family member had problems getting some of his over-the-counter (OTC) medications a while back so his family member signed a paper for the facility to get the OTC medications from the facility's primary pharmacy. Interview with the Health and Wellness Director (HWD) on 02/23/17 at 2:10 p.m. revealed: -The MAs had been trained to read the MARs and medication labels to make sure they match. -The MAs were supposed to check medications brought in by families with the orders in the record. -She was not aware Resident #7 was receiving the wrong dosage of Fish Oil. b.) Review of Resident #7's current FL-2 dated 09/28/16 revealed there was an order for Vitamin D3 1000 units 1 tablet once a day. (Vitamin D3 is used to treat Vitamin D deficiency.) Observation of the 8:00 a.m. medication pass on 02/23/17 revealed: -The medication aide (MA) prepared Resident #7's morning medications. -She did not administer Vitamin D3 1000 units to Resident #7 when the resident's other morning medications were administered at 8:31 a.m. Interview with the MA on 02/23/17 at 8:32 a.m. revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 106 -She did not administer Vitamin D3 to Resident #7 because there was none in the medication cart. -She would have to contact the resident's family member because they usually brought the resident's medications to the facility. Review of Resident #7's February 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Vitamin D3 1000 units take 1 tablet daily and it was scheduled to be administered at 8:00 a.m. -Vitamin D3 was not documented as administered on 02/21/17, 02/22/17, and 02/23/17 due to the medication was "not in". Review of a resident log note for Resident #7 dated 01/19/17 revealed the facility's HWD noted the resident's family member called to inform that he wanted all over-the-counter medications for Resident #7 to be ordered through the facility's primary pharmacy. Interview with the MA on 02/23/17 at 1:50 p.m. revealed: -She had not had time to contact Resident #7's family member about the Vitamin D. -She was not aware of the note in Resident #7's record to get his medications from the primary pharmacy. -She would check with the pharmacy. Interview with Resident #7 on 02/24/17 at 3:55 p.m. revealed: -Most of his medications came from a mail order pharmacy. -His family member helped with his medications. -His family member had problems getting some of his over-the-counter (OTC) medications a while back so his family member signed a paper	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 107 for the facility to get the OTC medications from the facility's primary pharmacy. Interview with a pharmacy technician from the primary pharmacy on 02/27/17 at 9:06 a.m. revealed: -Resident #7's medications were not on a cycle fill and had to be ordered by the facility. -They dispensed Vitamin D3 on the following days: 31 tablets on 10/26/16, 31 on 12/01/17, 31 on 01/19/17, and 30 on 02/23/17. C. Review of Resident #6's current FL-2 dated 01/03/17 revealed: -The resident's diagnoses included dementia, hypertension, rheumatoid arthritis, and seizure disorder. -There was an order for Zocor 20mg 1 tablet daily at bedtime. (Zocor lowers cholesterol.) Review of Resident #6's January 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Zocor 20mg take 1 tablet at bedtime. -The computer printed scheduled time for administration was 8:00 p.m. -Zocor was documented as administered at 8:00 p.m. in January 2017. Review of Resident #6's February 2017 MAR revealed: -There was a computer printed entry for Zocor 20mg take 1 tablet daily. -The computer printed entry for time of administration was marked out and 8:00 a.m. was handwritten on the MAR. Observation of the medication pass on 02/23/17 revealed Zocor 20mg was administered to Resident #6 at 8:58 a.m. instead of bedtime as	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 108 ordered. Interview with the medication aide (MA) on 02/23/17 at 10:18 a.m. revealed: -She thought the time for Zocor was changed to mornings because that was the way Resident #6 took it when she lived at home. -She assumed there was a physician's order to change it to morning administration. Review of Resident #6's physician's orders revealed no subsequent orders to administer Zocor in the mornings. Interview with the Health and Wellness Director (HWD) on 02/23/17 at 12:52 p.m. revealed: -She was not aware the time for administration of Resident #6's Zocor had been marked through and changed on the MAR. -There was no order to change it from bedtime to mornings. -Zocor should have been administered at bedtime. -She would notify the physician. Review of a physician's order request by the facility dated 02/23/17 for Resident #6 revealed: -The facility requested the physician clarify if the Zocor was to be given at bedtime. -The physician signed an order for Zocor 20mg at bedtime. 2. Review of Resident #2's current FL-2 dated 04/26/16 revealed the resident's diagnoses included senile dementia and depressive disorder. A. Review of the Resident #2's current FL-2 dated 04/26/16 revealed there was an order for Seroquel 50mg at bedtime. (Seroquel is an	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 109 antipsychotic.) Review of a physician's order dated 02/15/17 revealed an order to change Seroquel 50mg at bedtime to 50mg at bedtime prn (as needed) for agitation. Review a Resident Log note dated 02/15/17 at 10:00 p.m. for Resident #2 revealed the resident had new order to change Seroquel to 50mg at bedtime as needed for agitation. Review of the February 2017 medication administration record (MAR) for Resident #2 revealed: -There was a computer printed entry for Seroquel 50mg at bedtime. -Seroquel 50mg was documented as administered daily at 8:00 p.m. from 02/01/07 - 02/22/17. -The scheduled dose of Seroquel was not discontinued on the MAR when the order changed on 02/15/17. -There was a handwritten entry for Seroquel 50mg 1 tablet by mouth prn for agitation with a start date of 02/15/17 written beside it. -No prn Seroquel was documented as administered. Interview with the Health and Wellness Director (HWD) on 02/24/17 at 1:40 p.m. revealed: -The medication aide (MA) on duty was responsible for implementing new orders including transcribing on the MARs. -The MA who transcribed the prn order for Seroquel on 02/15/17 should have also marked through the scheduled order for Seroquel and discontinued it. -She was not sure which MA transcribed the order since they did not initial it.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 110 -She would correct the MAR and notify the physician of the medication error. Interview with the HWD on 02/27/17 at 11:18 a.m. revealed: -The MA on duty was responsible for transcribing orders and faxing orders to the pharmacy. -Once faxed, the order was put in a pending order folder and the MAs were supposed to use a new order tracking form. -She had not been reviewing the folder and the new order tracking forms were not being completed. -She and the Resident Care Coordinator (RCC) started implementing all new orders since Friday, 02/24/17. B. Review of the Resident #2's current FL-2 dated 04/26/16 revealed there was an order for MSM 1000mg take 1 capsule twice a day. (MSM is a natural supplement known to be used for pain and inflammation / arthritis.) Review of the January 2017 medication administration record (MAR) for Resident #2 revealed: -There was an entry for MSM 1000mg 1 twice daily and it was scheduled to be administered at 7:00 a.m. and 8:00 p.m. -MSM was not documented as administered from 01/01/17 - 01/11/17 due to the medication "not on cart" and "order from pharmacy". Review of the February 2017 MAR for Resident #2 revealed: -There was an entry for MSM 1000mg 1 twice daily and it was scheduled to be administered at 7:00 a.m. and 8:00 p.m. -MSM was not documented as administered from 02/13/17 - 02/20/17 due to the medication "not on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 111 cart". Review of medications on hand for Resident #2 on 02/24/17 revealed: -There was a supply of MSM 100mg tablets dispensed by the primary pharmacy on 02/20/17. -There were 53 of 60 tablets remaining. Interview with a medication aide (MA) on 02/24/17 at 1:27 p.m. revealed: -Resident #2's family member used to bring his over-the-counter medications -A few months ago, they got permission from Resident #2's family member to order his medications from the primary pharmacy. -She was not sure why MSM was unavailable in January and February 2017. -She did not know if the physician was notified. Interview with the Health and Wellness Director (HWD) on 02/24/17 at 1:40 p.m. revealed: -She was not aware Resident #2 had missed any doses of medication. -The MAs on duty were responsible for reordering medications or calling the family when there was about a one week supply left. -The MAs should let either her or the Resident Care Coordinator (RCC) know if they can't get a medication from the pharmacy or the family. -She thought Resident #2's family only supplied one of his medications but the MSM should be ordered from the pharmacy. Interview with Resident #2's family member on 02/27/17 at 10:28 a.m. revealed: -He usually supplied two of the resident's over-the-counter (OTC) medications. -They usually called him when there was a 2 to 3 day window before those 2 OTC medications ran out.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 112 -The facility was supposed to get all other medications, including MSM, from the facility's primary pharmacy. -He was not aware of the resident running out of any medications. Review of pharmacy dispensing records for Resident #2 from 09/2016 - 02/2017 revealed: -There were 60 (a 30 day supply) MSM 100mg tablets dispensed on 01/09/17. -There were 60 (a 30 day supply) MSM 100mg tablets dispensed on 02/20/17.	D 358		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on record review, interviews and observations, residents were free of mental and physical abuse, neglect, and exploitation in accordance with relevant federal and state laws and rules and regulations related to the use of sounding devices (door alarms) and personal care and supervision. The findings are: Based on record reviews, interviews, and observations, the facility failed to provide a sounding device (door alarm) for the front door for 4 of 4 sampled residents (Residents #1,#2, #5, #9) known to have dementia, were confused, disoriented, and who, unknown to staff, wandered away from the facility resulting in one resident death (#1). [Refer to Tag D 067 10A NCAC 13F	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	R 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(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
D914	Continued From page 113 .0305(h)(4) (Type A1 Violation)]. Based on record review, interviews, and observations, the facility failed to provide supervision and implementation of the wander guard system in the assisted living unit, in accordance with each resident's needs, care plan, and current symptoms for 4 of 4 sampled residents (Residents #1, #2, #9) known to have dementia, were confused, disoriented, and who, unknown to staff, wandered away from the facility resulting in one resident death (#1). [Refer to Tag D 270 10A NCAC 13F .0901(b) (Type A1 Violation)].	D914		

This Plan of Correction is not to be construed as an admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. The facility provided a detailed description of the corrective actions being undertaken by the facility, including exhibits and other documents, in its Response to Notice of Intent to Issue a Provisional License. To the extent necessary, we expressly incorporate into this Plan of Correction the facility's previously submitted Response.

10A NCAC 13F .0305(h)(4) Physical Environment

1. Residents' records will be reviewed for diagnoses of Dementia, intermittent or constant disorientation or at risk for wandering and/or elopement.
2. Residents with documentation in one or more of these areas will be assessed for risk factors and the primary physician will be notified.
3. Residents verified to be at risk will be evaluated for a Wander Guard. If deemed appropriate, a Wander Guard will be utilized and the resident's physician and family will be notified.
4. The Wander Guard system will remain active at all times any resident is wearing a Wander Guard alarm device. When a resident is within 2 feet of the door, the door will automatically lock and an alarm will sound. The staff will immediately respond to the alarm per Brookdale's policy for elopements.
5. All exit doors at the community are equipped with alarms that sound when opened. These doors are alarmed at all times. The front door is equipped with a sounding device which is operational whenever a resident who has been assessed as "at risk for wandering or elopement" but has not shown the need for a Wander Guard is living within the community.
6. Per the community's policy, the resident will be reassessed in two weeks and again at 30 days. If the resident continues to be at risk, the family and physician will be consulted and the resident will be evaluated for appropriate placement.
7. A resident found to be in need of a memory care unit will be issued a thirty day discharge notice and appropriate placement will be found.
8. The Executive Director (ED)/designee will review residents with Wander Guards at each Collaborative Care Review Meeting.
9. The Maintenance Technician/designee will be responsible for maintaining the Wander Guard System.
10. The Medication Aide/Supervisor in Charge (MA/SIC)/designee will be responsible for checking the Wander Guard for placement on the resident on each shift and documenting as appropriate on the Medication Administration Record (MAR).

The Date of Correction for this Type A1 Violation will not exceed March 30, 2017.

10A NCAC 13F .0802 (e) Resident Care Plan

1. Resident Records will be audited for currently signed Personal Service Plans (PSPs)
2. PSPs that are out of compliance will be updated, generated, signed by the Health and Wellness Director (HWD) or designee and delivered to the Provider's office for signatures.
3. A tracking system will be implemented for PSPs not immediately returned from a visit to the office.
4. After one week, the HWD/Designee will reach out to the Provider's office. After two weeks, the HWD/Designee will reach out to the Provider's office, family and county monitor. The family may be asked to contact the doctor and have the PSP signed by the physician.
5. The compliance tracker will be updated and maintained by the HWD and Resident Care Coordinator (RCC). The ED will monitor the compliance tracker on a weekly basis for four weeks and then monthly thereafter to maintain compliance.

The Date of Correction for this Standard Deficiency will not exceed April 30, 2017.

10A NCAC 13F .0901(b) Personal Care and Supervision

1. Residents will be assessed for supervision needs on admission and on an as needed basis thereafter.
2. Residents needing increased supervision will be identified and increased supervision will be implemented.
3. Interventions for residents with increased personal care and supervision needs will be implemented and entered on the resident service plan and added to the assignment sheet. These interventions may include but are not limited to increased monitoring, medication reviews, implementation of a Wander Guard device, and consults with other providers.
4. Increased monitoring following exit seeking behavior will be every 30 minutes for 24 hours, every 1 hour for 24 hours, and every 2 hours for 3 days. This will be recorded in the resident record each shift by the Medication Aide (MA). The Health and Wellness Director (HWD) or Designee will monitor on a daily basis to verify compliance.
5. Increased monitoring requiring Wander Guard usage will include monitoring of the Wander Guard system by the Maintenance Technician (MT)/designee.
6. Residents who continue to have a need for increased supervision beyond the 3 days or who continue to have exit seeking behaviors will be assessed by the physician for a higher level of care. Residents determined to need one to one supervision for any reason will have family notification and a companion will be required until discharged from the community or deemed by the physician to no longer need the one to one supervision.
7. Residents requiring the Wander Guard monitoring system will be reassessed in two weeks and then again at the end of thirty days. Residents continuing to require a Wander Guard monitor will be assessed by the physician for appropriateness for transfer to a memory care unit.

The Date of Correction for this Type A1 Violation will not exceed March 30, 2017

10A NCAC 13F .0902(b) Health Care

1. The community will utilize the New Order Tracking Form for new orders.
2. The Medication Aides (MA) will transcribe and/or implement the new order including Medication Orders, orders for lab, consults, etc. and a copy of the new order will be placed into the tracking binder.
3. The Health and Wellness Director (HWD), Resident Care Coordinator (RCC) or designee will review the binder twice per day to verify completion of the order.
4. The Executive Director (ED)/designee will review the binder on a weekly basis and as needed to provide additional verification.
5. Medication technicians will be trained on Acute Charting (Hot Box) guidelines.
6. Implementation of new orders will be documented in the resident record. Documentation will be entered on the "Hot Box" tracking form and documentation will be completed for 72 hours or until resolved.
7. The HWD/Designee will monitor the Hot Box tracking form and review charting on a daily basis.
8. The ED/designee will monitor the Hot Box tracking form and review random charts on a weekly basis to verify compliance.

The Date of Correction for this Standard Deficiency will not exceed April 30, 2017.

10A NCAC 13F .0902(c)(3-4) Health Care

1. The community will utilize the New Tracking Order Form for new Orders.
2. The Medication Aides (MA) will transcribe and/or implement the new order including Medication Orders, labs, therapy, referrals, etc. and then place a copy of the new order along with the New Order Tracking Form into the Tracking binder.
3. The Health and Wellness Director (HWD), Resident Care Coordinator (RCC) or designee will review the binder twice per day to verify completion of the order.
4. The Executive Director (ED)/designee will review the binder on a weekly basis and as needed to provide additional verification.
5. Medication technicians will be trained on Acute Charting (Hot Box) guidelines.
6. Implementation of new orders will be documented in the resident record. Documentation will be entered on the "Hot Box" tracking form and documentation will be completed for 72 hours or until resolved.
7. Lab orders and X-ray orders will be documented in a separate log for follow up.
8. The HWD/Designee will monitor the Hot Box tracking form and review charting on a daily basis.
9. The ED/designee will monitor the Hot Box tracking form and review random charts on a weekly basis to verify compliance.

The Date of Correction for this Standard Deficiency will not exceed April 30, 2017.

10A NCAC 13F .1004 (a) Medication Administration

1. The community will utilize the New Tracking Order Form for new Orders.
2. The Medication Aides (MA) will transcribe, enter into the eMAR (when available) and/or implement the new medication order and then place a copy of the new order along with the New Order Tracking Form into the Tracking binder.
3. The Health and Wellness Director (HWD), Resident Care Coordinator (RCC) or designee will review the binder twice per day to verify completion of the order.
4. The Executive Director (ED)/designee will review the binder on a weekly basis and as needed to provide additional verification.
5. Medication technicians will be trained on Acute Charting (Hot Box) guidelines.
6. Implementation of new orders will be documented in the resident record. Documentation will be entered on the "Hot Box" tracking form and documentation will be completed for 72 hours or until resolved.
7. Lab orders and X-ray orders will be documented in a separate log for follow up.
8. The HWD/Designee will monitor the Hot Box tracking form and review charting daily.
9. The ED/designee will monitor the Hot Box tracking form and review random charts on a weekly basis for accuracy.

The date of correction for this standard deficiency will not exceed April 30, 2017.

GS 131 D-21(4) Declaration of Resident Rights
(Corrected with the Type A1 Violations)