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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING: ADULT CARE LICENSURE SECTION RALEIGH B. WING	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

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D 000	Initial Comments The Adult Care Licensure Section and New Hanover County Department of Social Services conducted an annual, follow up and complaint investigation survey on October 21 and 22, 2021. The complaint investigation was initiated by the New Hanover County Department of Social Services on 09/09/21.	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: Based on record reviews, interviews, and observations, the facility failed to assure 1 of 7 exit doors were equipped with a sounding device that activated when the door was opened resulting in a resident who had a diagnosis of dementia exiting the free standing memory care unit unsupervised and found in the neighboring parking lot. The findings are:	D 067		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Donna Wheeler — Ops Specialist — 11/17/21

Reviewed and acknowledged. 21 December 2021.

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D 067	Continued From page 1	D 067		

Review of the facility's policy for "Exit Alarms and Wanderguard System" revealed:
-The policy overview. Alzheimer's/Dementia care communities have alarmed exterior doors and often have doors with a delayed egress feature; these systems are designed to alert associates to respond to and assist a resident should a resident wander from the community.
-The doors that lead to the outside are equipped with an alarm system to alert associates when a door has been opened. The alarm system must be activated at all times
-It is the responsibility of associates to respond when an alarm sounds.
-When an alarm sounds, associates should first check the display panel to determine which door(s) have been opened.
-Once the associate checks the display panel, that individual assumes responsibility for checking the door(s).
-An associate must go to the door(s) that has been opened to investigate the situation. When arriving at the door(s), the associate must: redirect any resident(s) who is near the door away from the exit; the associate should view the immediate area outside the door to locate any other residents who may have exited undetected; any such resident who has exited should be escorted back inside the community.
-During the time the situation at the door(s) is being investigated, another associate should initiate a head county of all residents.
-The policy was last revised November 2020.

Review of Resident #4's current FL-2 dated 09/02/2021 revealed:
-Diagnoses included Alzheimer's dementia, asthma, and environmental allergies.
-The resident was intermittently disoriented and

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D 067	Continued From page 2	D 067		

wandered.
-The resident was ambulatory.
-The resident's level of care was documented as memory care.

Review of the incident report dated 09/17/21 revealed:
-The nature of the incident was an elopement at approximately 5:50pm.
-The location of the incident was outside the building.
-The follow up information indicated: Resident #4 walked out the B Hall door, stating he was going home; the resident was in the parking lot, stopped walking when staff was walking towards him; the resident walked beside staff member and did not attempt to leave the staff's side as the resident came back into the community without any problem; staff provided 1:1 monitoring until a 1:1 private sitter came.

Review of Resident #4's electronic progress note dated 09/17/21 at 5:50pm revealed:
-Resident #4 was in dining room eating when the resident decided to exit out the door on B hall.
-The medication aide (MA) responded to the door alarm going off by checking closest panel on C hall and saw B hall alarm was going off.
-The MA went to check doors and did not see no one in hallway.
-The MA continued to check rooms for resident as loud secondary door alarm was not heard.
-The personal care aide (PCA) noticed the red light wasn't flashing in back exit door on B hall and said that the resident could have gotten out without alarm going off on that door.
-The MA and PCA went out the door and saw resident walking across parking lot.
-The MA called the resident who turned and walked towards the MA.

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D 067	Continued From page 3 -The resident stated he lived close by and wanted to go home. The resident returned to the facility and was assigned 1:1 care. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Observation of exit doors on B hall on 09/16/21 at 10:00am revealed: -There is a continuous beep when the interior exit door was pushed. -The interior exit door led to a corridor where a panel was displayed on the wall. -There was a flashing red light flashing on the panel. -Above the panel in the corridor was a signed posted that read: red light must blink to lock door; turn then wait until you hear a click. -The exterior exit door had a signed posted on door: push until alarm sounds, door can be opened in 15 seconds. -The exterior exit door had a loud siren sound when the door was opened. Telephone interview with a MA on 10/07/21 at 4:23pm revealed: -The MA was from a staffing agency and worked second shift (3:00pm-11:00pm) on 09/17/21 when Resident #4 eloped from the facility. -The MA was serving dinner between 5:00pm-5:30pm when the MA heard a continuous beep. -The MA on 09/17/21 checked the panel and determined the interior exit door on B hall had been opened/activated. -The MA opened the interior exit door, but she did not see any residents in the corridor or in any rooms on B hall. -A PCA noticed the panel in the corridor on B hall	D 067		

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D 067	Continued From page 4	D 067		

was not blinking red, which meant the door was not armed (locked), which was why the loud siren sound did not sound for the exterior exit door when it was opened
-When she and PCA went out the exterior exit door, Resident #4 was observed outside the building.
-Resident #4 was found walking across parking lot of facility, which was located next to facility.
-She did not know to check the panel in the corridor to ensure the red light was flashing red to ensure the door was locked, as she had not been trained to do so
-She did not know to check the exterior exit door.
-The MA indicated that prior to 09/17/21, the MA had not received any education regarding the facility's policy related to the exit doors, as the doors and door alarms were not part of her hiring orientation.
-The MA indicated that she was only told to turn off the alarm if the exit door alarms sounded

Telephone interview with a PCA on 10/07/21 at 7:16pm and an interview on 10/21/21 at 4:35pm revealed:
-The PCA worked second shift on 09/17/21 when Resident #4 eloped from the facility.
-The PCA was a facility employee.
-On 09/17/21, the PCA heard a continuous beep about 5:30pm.
-When the alarm (continuous beep) was heard, the other staff members did not know what the alarm was and what to do.
-When the PCA got to the interior exit door on B hall, the alarm was beeping.
-The PCA went to check the exterior exit door and noticed the red light on the panel in the corridor was not flashing red, which meant the exterior door was not armed/locked.
-If the red light was not flashing, the exterior door

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D 067	Continued From page 5	D 067		

alarm (which was extremely loud) would not sound.
-Whoever went out the exterior exit door on B hall prior to the elopement did reset the door for the alarm to sound.
-When the PCA and MA went out the exterior exit door on B hall, Resident #4 was observed walking in a parking lot beside the facility.
-The other staff members who worked on 09/17/21 did not have know to check the panel in the corridor for flashing red light and to check the exterior exit door, as they were from a staffing agency.
-Prior to 09/17/21, the facility had not trained agency staff on the facility policies related to the door alarms.

Interview with the maintenance director on 10/21/21 at 3:35pm revealed:
-The interior exit door will alarm with a continuous beep when activated.
-The continuous beeping can only be silenced at main annunciator, located at the front of the building by the Administrator's office.
-Once silenced, the door can only be reset on that hall where door is alarmed.
-The interior exit door requires a code to be entered on hallway keypad to stop the blinking light when the door is activated, as the door will to be armed until the code is entered.
-The exterior exit door has a different set up.
-The exterior exit door did not have a continuous beep, as it has a louder siren sound.
-The panel in the corridor between the interior and exterior exit door needed to be blinking red, which meant the door was armed.
-He had modified the panel due to the 09/17/21 elopement because if a key had been used to disarm the door no one knew.
-Now if the door was not armed it alarm will

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D 067	Continued From page 6 sound when opened. -The facility had not been able to determine why the exterior exit door was not armed. Interview with the Operations Specialist/Interim Administrator on 10/22/21 at 2:25pm revealed: -The facility had not been able to determine why the exterior exit door on B hall was not armed to sound when opened on 09/17/21. -The agency staff members who worked on 09/17/21 did not know to check the panel in the corridor for a flashing red light to ensure the exterior exit door was locked/armed. -Prior to 09/17/21, the facility had not trained the agency staff on the facility's policies and procedures related to the door alarms and how to respond to the exit door alarms. -The Operations Specialist/Interim Administrator would expect that all door alarms were activated to sound if opened to ensure the safety of the residents, as the facility was a free standing memory care facility.	D 067		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by:	D 113		

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D 113	Continued From page 7	D 113		

TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 13 of 13 sinks sampled that were readily accessible and used by residents in the special care unit (SCU) facility with hot water temperatures ranging from 118 degrees F to 129.8 degrees F.

The findings are:

Review of the facility's current license effective 01/01/21 revealed the facility was licensed as a special care unit (SCU) facility with a capacity of 38 beds.

Review of the facility's census report dated 10/21/21 revealed
-The facility's in-house census was 26 residents.
-There were 8 SCU residents residing on A hall.
-There were 6 SCU residents residing on B hall.
-There were 6 SCU residents residing on C hall.
-There were 6 SCU residents residing on D hall.

Observation of resident room D1 on the D hall on 10/21/21 at 9:31am revealed:
-There was one ambulatory SCU resident residing in the room.
-The hot water temperature at the bathroom sink was 122 degrees Fahrenheit (F) with visible steam.
-There were no caution signs posted for the hot water temperatures.

Based on observations, interviews, and record reviews, it was determined the resident residing in room D1 was not interviewable.

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D 113	Continued From page 8	D 113		

Observation of resident rooms A4 and A7 on the A hall on 10/21/21 from 9:20am - 9:25am revealed:
-The water temperatures at the bathroom sinks in both rooms were 118 degrees F with visible steam.
-There were no signs posted over the sinks in either room to caution the water was hot.
-The residents were not in the rooms at the time.

Based on observations, interviews, and record reviews, it was determined the resident residing in room A4 was not interviewable.

Based on observations, interviews, and record reviews, it was determined the resident residing in room A7 was not interviewable.

Observation of resident room C8 on the C hall on 10/21/21 at 9:10am revealed:
-There was one ambulatory SCU resident residing in the room.
-The hot water temperature at the bathroom sink was 123 degrees F with visible steam.
-There were no caution signs posted for the hot water temperatures.

Observation of resident room C7 on the C hall on 10/21/21 at 9:13am revealed:
-There was one ambulatory SCU resident residing in the room.
-The hot water temperature at the bathroom sink was 125 degrees F with visible steam.
-There were no caution signs posted for the hot water temperatures.

Observation of resident room C2 on the C hall on 10/21/21 at 9:17am revealed:
-There was one non-ambulatory SCU resident

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D 113	Continued From page 9	D 113		

residing in the room.
-The hot water temperature at the bathroom sink was 122 degrees F with visible steam.
-There were no caution signs posted for the hot water temperatures.

Observation of resident room C5 on the C hall on 10/21/21 at 9:20am revealed:
-There was one ambulatory SCU resident residing in the room.
-The hot water temperature at the bathroom sink was 124 degrees F with visible steam.
-There were no caution signs posted for the hot water temperatures.

Interview with a personal care aide (PCA) on 10/21/21 at 9:25am revealed:
-She had not given any residents any baths on 10/21/21.
-The water in the common bathrooms and resident room sinks were hot at times.
-Most of the time she had to add cold water to make water temperature warm for residents.
-She had not received any instructions from management that water temperatures were too hot.

Interview with a second PCA on 10/22/21 at 8:09am revealed:
-The water temperatures were hot at times which required her adjust the water temperature by adding cold water.
-She was not aware of any issues related to water temperatures being too hot.
-She had not been instructed by management to monitor water temperatures.

Observation of resident room B8 on the B hall on 10/21/21 at 9:13am revealed:
-The hot water temperature at the bathroom sink

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D 113	Continued From page 10	D 113		

was 129.4 degrees F.
-There was no caution sign posted for the hot water temperature.

Based on observations, interviews, and record reviews, it was determined the resident residing in room B8 was not interviewable.

Observation of resident room B7 on the B hall on 10/21/21 at 9:16am revealed:
-The hot water temperature at the bathroom sink was 129.8 degrees F.
-There was no caution sign posted for the hot water temperature.

Based on observations, interviews, and record reviews, it was determined the resident residing in room B7 was not interviewable.

Observation of resident room B6 on the B hall on 10/21/21 at 9:19am revealed:
-The hot water temperature at the bathroom sink was 124.8 degrees F.
-There was no caution sign posted for the hot water temperature.

Based on observations, interviews, and record reviews, it was determined the resident residing in room B6 was not interviewable.

Observation of resident room B2 on the B hall on 10/21/21 at 9:29am revealed:
-The resident was sleeping in the bed and there were no ambulation assistive devices in the room.
-The hot water temperature at the bathroom sink was 124.2 degrees F.
-There was no caution sign posted for the hot water temperature.

Based on observations, interviews, and record

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D 113	Continued From page 11	D 113		

reviews, it was determined the resident residing in room B2 was not interviewable.

Observation of resident room B5 on the B hall on 10/21/21 at 9:32am revealed:
-The hot water temperature at the bathroom sink was 125 degrees F
-There was no caution sign posted for the hot water temperature.

Based on observations, interviews, and record reviews, it was determined the resident residing in room B5 was not interviewable.

Observation of resident room B4 on the B hall on 10/21/21 at 9:35am revealed:
-The hot water temperature at the bathroom sink was 127.5 degrees F.
-There was no caution sign posted for the hot water temperature.

Based on observations, interviews, and record reviews, it was determined the resident residing in room B4 was not interviewable.

Interview with a personal care aide (PCA) on 10/21/21 at 9:23am revealed:
-The resident in room B6 was ambulatory and frequently wandered all halls and into other residents' rooms.
-Residents in rooms B2, B4 and B5 were also ambulatory.
-He did not run just hot water from fixtures.
-He normally ran both hot and cold water simultaneously, then adjusted both until the water was warm enough

Interview with the housekeeper on 10/21/21 at 9:51am revealed:
-Sometimes the hot water was too hot.

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D 113	Continued From page 12	D 113		

-She remembered only two occasions when the hot water was too hot
-The last time was about one month ago (September 2021) and she mentioned it to the Maintenance Director

Observations of hot water temperatures from the sink fixture in resident room B7 with the transportation staff on 10/21/21 at 10:03am revealed:
-The facility's thermometer used by the transportation staff showed the arrow between 124 and 126 degrees F
-The surveyor's digital thermometer showed a temperature of 128.1 degrees F

Observations of the facility's hot water heaters on 10/21/21 at 10:09am revealed:
-Two hot water tanks with pipes leading to a mixing valve identified by the transportation person.
-The mixing valve had a temperature dial with the needle on 134 degrees F.
-There was an "L" wrench connected at the top of the mixing valve.

Interview with the transportation staff on 10/21/21 at 10:01am revealed:
-He had previously worked as a maintenance staff and was responsible for checking hot water temperatures when he worked in maintenance
-He no longer checked hot water temperatures, but he was familiar with the process
-The current Maintenance Director was responsible for checking hot water temperatures
-He could feel the hot water was too hot and needed to be adjusted
-The hot water temperatures were not supposed to exceed 116 degrees F.
-Staff were expected to tell him or the

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(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 113	Continued From page 13	D 113		

Maintenance Director when there was an issue with hot water temperatures.
-The mixing valve was adjustable by the "L" wrench, but he did not know how adjustments were made.

Interview with the Maintenance Director (Operations Specialist/Interim Administrator present) on 10/21/21 at 10:27am revealed:
-He completed weekly temperature checks and documented the results on the facility's computer system.
-He knew the hot water was "getting out of line" with temperatures of 125 to 126 degrees F earlier that week (10/18/21-10/20/21).
-He tried to adjust the temperature and let it sit for one day, but the hot water temperatures did not decrease.
-There were two hot water heaters at the facility with a common mixing valve.
-There was a set screw and temperature valve on top of the mixing valve.
-He was able to adjust the amount of hot water entering the mixing valve by adjusting the set screw at the mixing valve.
-He submitted an electronic request for a plumber through the facility's computer system on 10/20/21.
-He did not notify staff to use caution with hot water.
-He did not report the increased hot water temperatures.
-He thought hot water temperatures were supposed to be maintained between 110 and 113 degrees F.
-Each shower had a thermo activated flow reducer (TAFR) valve which stopped the flow of hot water if the temperature get too hot.
-The TAFR valve had a factory set temperature limit which he was not sure of.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING: _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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 113	Continued From page 14	D 113		

Interview with the Operations Specialist/Interim Administrator on 10/21/21 at 10:27am revealed:
-The Maintenance Director was responsible for checking hot water temperatures.
-There was an electronic log with documentation of weekly hot water temperatures.
-There were weekly meetings with managers from each department and that was when something like increased hot water temperatures would have been reported.
-The meeting had not yet occurred for the week of 10/18/21 so the increased hot water temperatures had not yet been reported.

Review of the facility's "Logbook Documentation" dated 09/04/21 through 10/15/21 revealed:
-Weekly documentation of hot water temperatures of 3 fixtures and the mixing valve.
-Hot water temperatures at fixtures ranged from 112 to 117 degrees F.
-On 09/24/21, the hot water temperature of the mixing valve was 120 degrees F.

Second interview with the Operations Specialist/Interim Administrator on 10/21/21 at 11:17am revealed a plumber was currently at the facility to check the hot water heater and adjust the hot water temperature.

Second observation of resident room D1 on the D hall on 10/21/21 at 2:56pm revealed the hot water temperature at the bathroom sink was 94 degrees F.

Second observation of resident room A7 on the A hall on 10/21/21 at 3:30pm revealed the water temperature at the private bathroom sink was 96 degrees F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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 113	Continued From page 15 Second observation of resident room A4 on the A hall on 10/21/21 at 3:35pm revealed the water temperature at the private bathroom sink was 94 degrees F. Second observation of resident room C8 on the B hall on 10/21/21 at 2:48pm revealed the water temperature at the private bathroom sink was 94 degrees F. Second observation of resident room C7 on the B hall on 10/21/21 at 2:51pm revealed the water temperature at the private bathroom sink was 92 degrees F. Second observation of resident room C5 on the B hall on 10/21/21 at 2:53pm revealed the water temperature at the private bathroom sink was 90 degrees F. Second observation of resident room C2 on the B hall on 10/21/21 at 2:55pm revealed the water temperature at the private bathroom sink was 90 degrees F. Second observation of resident room B8 on the B hall on 10/21/21 at 2:45pm revealed the water temperature at the private bathroom sink was 93.5 degrees F. Second observation of resident room B7 on the B hall on 10/21/21 at 2:49pm revealed the water temperature at the private bathroom sink was 90.7 degrees F. Second observation of resident room B6 on the B hall on 10/21/21 at 2:51pm revealed the water temperature at the private bathroom sink was 88.4 degrees F.	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING: _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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 113	Continued From page 16	D 113		

Second observation of resident room B4 on the B hall on 10/21/21 at 2:54pm revealed the water temperature at the private bathroom sink was 88.6 degrees F

Second observation of resident room B5 on the B hall on 10/21/21 at 2:58pm revealed the water temperature at the private bathroom sink was 87.6 degrees F.

Interview with the Maintenance Director (Operations Specialist/Interim Administrator present) on 10/21/21 at 10:27am revealed the temperature valve on the mixing valve usually showed a temperature 4 to 6 degrees F higher than hot water from fixtures in the facility.

Second interview with the Maintenance Director on 10/21/21 at 3:59pm revealed
-He had rechecked the hot water temperatures that afternoon following the adjustment by the plumber.
-He did not get temperatures below 100 degrees F.
-The mixing valve was currently set at 100 degrees F (which would be 4 to 6 degrees higher than temperatures in fixtures in resident rooms)
-He planned to recheck hot water temperatures the morning of 10/22/21

The facility failed to ensure hot water temperatures for 13 of 13 sink fixtures in the facility that were accessible to and used by the special care unit (SCU) residents with diagnoses of dementia or other cognitive disorders, were maintained between 100 - 116 degrees F. The hot water temperatures out of the required range at the sinks accessible to the SCU residents ranged from 118 degrees F to 129.8 degrees F with visible steam. A water temperature of 118.4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING: _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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 113	Continued From page 17 degrees F could result in a first degree in 15 minutes and a second degree burn in 20 minutes. A water temperature of 127.4 degrees could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. A third degree burn can occur in 10 seconds when skin is placed in contact with water measuring 130 degrees F. This failure of the facility was detrimental to the safety, health and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/21/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 6, 2021.	D 113		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to submit completed accident and incident reports to the local Department of Social Services (DSS) for 3 of 4 sampled residents (#1, #3 and #5) who experienced incidents resulting in the need for	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING: _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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 451	Continued From page 18	D 451		

evaluation and treatment at the emergency department.

The findings are:

Review of the facility's "Incident Report Policy" revealed:
-An incident report much be completed in the event that a resident or visitor experiences an occurrence that is unusual, improper, or harmful. Incidents may include, but are not limited to, injuries, falls, theft, unexplained absence, sudden illness, and combative behavior. The resident's physician, family and responsible person and sponsoring agency, if applicable, should be notified.
-Incidents or accidents resulting in death or requiring referral for emergency medical evaluation, hospitalization or medical treatment other than first aid shall be reported to the Department of Social Services (DSS). The completed reports should be printed and submitted to the DSS by mail, fax, electronic mail, or in person within 48 hours of the initial discovery or knowledge by associates of the accident or incident.
-The policy was last revised October 2012

1. Review of Resident #5's current FL-2 dated 10/04/21 revealed:
-Diagnoses included dementia, Alzheimer's, depression, thyroid disorder, and seizure.
-The resident was constantly disoriented and wandered
-The resident was ambulatory.
-The resident was incontinent of bowel and bladder.
-The resident required assistance with bathing and dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING: _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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 451	Continued From page 19	D 451		

Review of Resident #5's electronic progress note dated 10/19/21 at 10:18pm revealed:
-The resident was sent to the emergency room (ER) for a fall with head laceration.
-The resident's note was completed by a nurse.

Review of the local hospital report dated 10/19/21 revealed:
-Resident #5 went to the ER for a fall and head laceration.
-Resident #5's diagnosed included fall, laceration of left eyebrow, and contusion of face.

Review of the facility's incident report dated 10/19/21 for Resident #5 revealed:
-At 4:10pm, Resident #5 had a witnessed fall in the dining room.
-Resident #5 injuries were documented as cut/laceration and head injury.
-Resident #5 was sent to the ER for treatment and assessment.
-The notification information for state agency had two X marks for each section: name, date notified, time notified, associate who notified, and method of notification.
-There was no documentation of notification via fax or phone call to DSS.

Observation of Resident #5 on 10/21/21 at 12:15pm revealed:
-There was purplish red bruising around the resident's left eye.
-The resident's left eyelid was swollen and there was swelling underneath her left eye.
-The resident's left facial cheek was swollen with multiple scattered bruises of various shades of purple.

Interview with the local Department of Social Services (DSS) Social Worker/Adult Home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING: _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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 451	Continued From page 20 Specialist on 10/22/21 at 4:40pm revealed: -The facility was responsible for faxing incident reports to DSS for any incident that happened which required more than first aide. -She monitored the facility multiple times and the staff or management never informed her of the incidents for Resident #5. -She had not received an incident report dated 10/19/21 for Resident #5. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. Refer to telephone interview with the Interim Health and Wellness Director (HWD) on 10/22/21 at 4:45pm Refer to interview with the Operations Specialist / Interim Executive Director (ED) on 10/22/21 at 5:46pm 2. Review of Resident #1's current FL-2 cated 08/16/21 revealed diagnoses included dementia with behavioral disturbance and osteoarthritis. a. Review of an electronic progress note dated 06/13/21 at 2:02pm for Resident #1 revealed: -The resident grabbed and hit the arm of a female resident. -After being separated from the female resident, he charged at 2 staff. -He was sent to the emergency room (ER) for evaluation of aggressive and harmful behavior. Review of the facility's incident report for Resident #1 dated 06/13/21 2:20pm revealed: -He was the aggressor in a resident to resident incident by grabbing the arm of another resident. -No apparent injuries.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING: _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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 451	Continued From page 21	D 451		

-He was sent to the ER.
-The Health and Wellness Director (HWD), family member and primary care provider (PCP) were notified.
-No documentation the Department of Social Services (DSS) was notified.

Interview with the Operations Specialist/Interim Administrator on 10/22/21 at 5:51pm revealed:
-The former HWD and/or Administrator would have been responsible for faxing incident reports to DSS in June 2021.
-The former HWD terminated employment at the facility in July 2021 and the Administrator was current out on leave.

b. Review of an electronic progress note dated 06/26/21 at 3:16pm for Resident #1 revealed he was found on the floor with a head injury and was sent to the emergency room (ER).

Review of the facility's incident report for Resident #1 dated 06/26/21 8:00am revealed:
-He had an unwitnessed fall in his room.
-He had a scrape/abrasion on his skull/scalp.
-He was sent to the ER.
-The Health and Wellness Director (HWD), family member and primary care provider (PCP) were notified.
-No documentation the Department of Social Services (DSS) was notified.

Telephone interview with the medication aide (MA) on 10/22/21 at 11:59am revealed:
-His family member found him on the floor then came and got her.
-She called emergency medical services (EMS) and the resident was transported to the ER.
-She completed an incident report, called the HWD and faxed the PCP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING: _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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 451	Continued From page 22	D 451		

-She would have been responsible for calling the Adult Home Specialist (AHS) with the county DSS.
-If the facility nurse was there, the nurse would have taken over with notifying the PCP, family member and DSS.
-She was told by the facility nurse that DSS only needed to be contacted if a resident eloped from the facility.
-She was responsible for completing the incident report giving the completed report to the HWD and then the HWD notified the PCP, family member and DSS
-If the HWD was not at the facility, the MA was responsible for contacting DSS.

Interview with the local Department of Social Services (DSS) Social Worker/Adult Home Specialist on 10/22/21 at 4:40pm revealed.
-The facility was responsible for faxing incident reports to DSS for any incident that happened which required more than first aide.
-She monitored the facility multiple times and the staff or management never informed her of the incidents for Resident #1.
-She had not received incident reports dated 06/13/21 and 06/26/21 for Resident #1

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

Refer to telephone interview with the Interim Health and Wellness Director (HWD) on 10/22/21 at 4:45pm.

Refer to interview with the Operations Specialist / Interim Executive Director (ED) on 10/22/21 at 5:46pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING: _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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 451	Continued From page 23 3. Review of Resident #2's current FL-2 dated 05/26/21 revealed: -Diagnoses included Alzheimer's disease and osteoporosis. -The resident was intermittently disoriented. -The resident was ambulatory and had wandering behaviors. Review of Resident #2's personal service plan dated 06/28/21 revealed: -The resident had a history of falls and dizziness and was a risk for falls. -The resident could walk but may have episodes of weakness. Review of Resident #2's progress notes dated 09/29/21 revealed: -At 1:50pm, the resident had an unwitnessed fall in the sun room and hit his head on concrete. -The resident had a scrape on the right side of his head with a small amount of bleeding. -There was no loss of consciousness. -Staff called 911 and the resident was transported to the hospital for evaluation and treatment. -At 5:29pm, the resident returned from the emergency room (ER) following evaluation from a fall; no injuries were found and there were no new orders. -At 10:36pm, the resident was alert and oriented and denied pain or discomfort; had abrasion on right side of forehead but no bleeding was noted. Review of Resident #2's after visit summary from the hospital dated 09/29/21 revealed: -The resident was seen for a fall. -The resident had scans of the cervical spine, head, and chest and x-rays of the chest and pelvis. -The resident was diagnosed with an abrasion of the scalp.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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 451	Continued From page 24	D 451		

Review of Resident #2's incident/accident (I/A) report dated 09/29/21 revealed:
-The resident had an unwitnessed fall on the porch at approximately 1:50pm.
-The resident had a scrape / abrasion on his scalp.
-Emergency Medical Services (EMS) was called and the resident was sent to the ER.
-The data on the report was entered by the Interim Health and Wellness Director (HWD).
-The family was called and the primary care provider (PCP) was faxed regarding the fall.
-There was no documentation the county Department of Social Services (DSS) was notified as required.

Interview with the local Department of Social Services (DSS) Social Worker/Adult Home Specialist on 10/22/21 at 4:40pm revealed:
-The facility was responsible for faxing incident reports to DSS for any incident that happened which required more than first aide.
-She monitored the facility multiple times and the staff or management never informed her of the incidents for Resident #2.
-She had not received an incident report dated 09/29/21 for Resident #2.

Telephone interview with the Interim HWD on 10/22/21 at 4:45pm revealed:
-She was at the facility on 09/29/21 when Resident #2 had an unwitnessed fall on the porch.
-She documented the information on the I/A report dated 09/29/21.
-If the county DSS had been notified, it would have been documented on the I/A report.
-She did not notify the county DSS of Resident #2's fall on 09/29/21 because she probably

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING: _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 451	Continued From page 25	D 451		

thought the Operations Specialist/Interim Executive Director (ED) had done it.

Interview with the Operations Specialist / Interim ED on 10/22/21 at 5:46pm revealed:
-She did not notify the county DSS of Resident #2's fall on 09/29/21.
-Either she or the HWD should have notified the county DSS of Resident #2's fall on 09/29/21.
-She did not have a system to check to ensure the county DSS was notified of incidents/accidents.

Refer to telephone interview with the Interim Health and Wellness Director (HWD) on 10/22/21 at 4:45pm.

Refer to interview with the Operations Specialist / Interim Executive Director (ED) on 10/22/21 at 5:46pm.

Telephone interview with the Interim Health and Wellness Director (HWD) on 10/22/21 at 4:45pm revealed:
-If the county DSS was notified of an incident/accident, it would be documented on the I/A report.
-Either the ED or the HWD were responsible for notifying the county DSS of incidents/accidents.
-The ED was currently on leave and the Operations Specialist was filling in as the Interim ED.
-There was a breakdown in communication and she thought the Operation Specialist/Interim ED was notifying the county DSS while the Operations Specialist/Interim ED probably thought she was notifying the county DSS.

Interview with the Operations Specialist / Interim

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

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D 451	Continued From page 26 Executive Director (ED) on 10/22/21 at 5:46pm revealed: -The medication aides (MAs) or the HWD were responsible for filling out the I/A reports. -If a MA filled out the report, the MA would give the report to the HWD. -The HWD or the ED were responsible for calling the county DSS or emailing the I/A reports to the county DSS. -The HWD position had been vacant since July 2021 so they currently had an Interim HWD. -The ED was on leave so she was filling in as the Interim ED. -She did not have a system to check to ensure the county DSS was notified of incidents/accidents.	D 451		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of mental and physical abuse, neglect, and exploitation related to hot water temperatures. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065019	A. BUILDING: _____ B. WING _____	R 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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
D912	Continued From page 27 100 degrees Fahrenheit (°F) to a maximum of 116°F for 13 of 13 sinks sampled that were readily accessible and used by residents in the special care unit (SCU) facility with hot water temperatures ranging from 118 degrees F to 129.8 degrees F. [Refer to Tag 113 10A NCAC 13F .0311(d) Other Requirements (Type B Violation).]	D912		

11-19-21

Brookdale Wilmington HAL 065019 SOD E63J11

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.

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

1. All exit door alarms have been confirmed to be in working order. (Checked by Johnson Controls)
2. Secondary audio alert added to each exterior door to ensure that exterior door alarm is engaged.
3. Maintenance Director will routinely check the door alarms on a weekly basis and maintain documentation in TELS.
4. The Executive Director will monitor TELS weekly for four weeks and then monthly for verification of documentation of door alarm checks.
5. Current staff have been retrained. Newly hired and agency staff will be trained on response to door alarms and this documentation will be retained in the associate's file. This training will include but is not limited to:
    a. Immediate response to exit alarms;
    b. Visual check inside and outside of the door with the activated alarm;
    c. Head count to verify all residents are present;
    d. Resetting of the alarms.

The date of correction for this standard deficiency will not exceed December 10, 2021.

10A NCAC 13F .0311(d) Other Requirements

1. The hot water temperature has been confirmed to be in compliance.
2. The Maintenance Director will check water temps at least weekly and enter into TELS.
3. The Executive Director will monitor TELS weekly for four weeks and then monthly for verification of documentation and compliance.
4. Current staff have been retrained. Newly hired and agency staff will receive training on the appropriate response to elevated hot water temperature. This training will include but is not limited to:
    a. Immediate reporting of water that is too hot to touch and/or steaming from the faucet.
    b. Posting of hot water warning signs immediately upon discovering the water temperature is out of compliance.

The date of correction for this Type B Violation will not exceed November 26, 2021.

11-19-21

10A NCAC 13F .1212 Reporting of Accidents and Incidents

1. The Health and Wellness Coordinator (HWC) or designee will log incidents in the Brookdale Accident Incident Reporting system (BAIRs) within 48 hours. The Health and Wellness Director (HWD) or designee will review for accuracy and lock the report.
2. Accidents/incidents requiring outside assessment or treatment or deaths resulting from an accident or incident will be submitted to the county within 48 business hours of initial discovery. The RCC or designee will submit the Incident Report (IR) to the county.
3. The Executive Director/Designee will monitor the BAIRs system daily Monday - Friday for four weeks to ensure that all reports related to accidents and incidents requiring reporting to the county are submitted in the appropriate time frame.
4. The ED/Designee will then monitor weekly by generating a report for review for four weeks and then monthly and prn thereafter.

The Date of Correction for this Standard Deficiency will not exceed December 10, 2021.

Donna Hopkins, Ops Specialist
Brookdale Wilmington