STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014010	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LENOIR	1145 POWELL ROAD NE LENOIR, NC 28645

(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 conducted an annual survey on 08/30/22 - 08/31/22.	D 000		
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 and interviews, the facility failed to ensure physician's orders were implemented for 1 of 5 sampled residents (#1) related to an order for a urinalysis. The findings are: Review of Resident #1's current FL2 dated 03/02/22 revealed diagnoses included Parkinson's disease (central nervous system disorder that affects movement) and encephalopathy (disease of the brain that affects function or structure). Review of physician's orders for Resident #1 revealed an order for a urinalysis (a microscopic test of the urine) with culture and sensitivity dated 07/20/22. Review of Resident #1's laboratory results from 07/01/22 - 08/30/22 revealed no results of a urinalysis.	D 276	1). Resident #1 U/A order for culture and sensitivity was discontinued ,symptoms resolved, no new additional orders noted. 2). A review of orders for currnet residents in the last three months to ensure completion of physician orders. 3). Re-training on the new order process by the Health and Wellness Director to the Resident Care Coordinator and medication aides to ensure orders are noted and completed per physician orders. 4). A review of the new order process will be conducted by the Health and Wellness Director / designee weekly times three weeks and random monthly for three months.	10/7/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Holly Laurie

TITLE: District Director of Operations

(X6) DATE: 9-16-22

Reviewed and acknowledged 09/16/22

RP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 276	Continued From page 1 Interview with the Health and Wellness Director (HWD) on 08/30/22 at 11:53am revealed: -She had been out of the facility when the order for the urinalysis was received. -The Resident Care Coordinator (RCC) should have sent the order to the local home health agency. -The RCC should have followed up on the urinalysis order to ensure it had been completed. Interview with the RCC on 08/30/22 at 11:56am revealed: -The staff had been unable to collect a urine sample and the local home health agency should have been contacted to collect the urine sample. -The HWD was responsible for following up on all orders to ensure they were completed but she had been out of the facility on leave. -The RCC was responsible for following up on the orders to ensure completion when the HWD was not in the facility. -The RCC had missed the order for the urinalysis. Telephone interview with the facility's contracted Physician's Assistant (PA) on 08/30/22 at 12:00pm revealed: -She had ordered the urinalysis for Resident #1 due to an increase in confusion. -Resident #1's Parkinson's Disease sometimes caused an increase in confusion and it was difficult to determine if it was a urinary tract infection or the Parkinson's disease that was causing the confusion. -Resident #1 was not having any other symptoms of a urinary tract infection. Interview with the Administrator on 08/30/22 at 3:15pm revealed: -The HWD and RCC were responsible for ensuring all orders were complete.	D 276		

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D 276	Continued From page 2 -The order for the urinalysis had been "overlooked". Based on interviews and record review it was determined that Resident #1 was not interviewable.	D 276		