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
	HAL014010	A. BUILDING: _____ B. WING _____	R 03/18/2026

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 and follow-up survey on 03/17/26 through 03/18/26.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations and interviews, the facility failed to maintain a hazard-free environment related to seven unsecured oxygen (O2) tanks. The findings are: Observation of resident room #9 on 03/17/26 at 10:06am revealed: -There were two beds in the room. -A housekeeper was cleaning the bathroom located in the room. -There were six, 36-inch tall unsecured O2 tanks	D 079		

LSB 4/20/26 Reviewed and acknowledged

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D 079	Continued From page 1 in the room. -One tank was near the resident's headboard, another near the dresser, one by the bathroom door and three next to a chair. -There was a 12-slot O2 storage crate in the room that contained six O2 tanks and four pairs of shoes; two of the slots were empty. Interview with a resident on 03/17/26 at 10:06am revealed: -She was one of two residents that lived in room #9 and she used the O2 tanks when she left the room. -The unsecured O2 tanks were empty and she did not know they needed to be in a crate to secure them. -She knew O2 tanks should be handled carefully and should not fall over. -She "knocked one over" going to the bathroom recently and had to put it back in the upright position. Interview with a housekeeper on 03/17/26 at 10:06am revealed he did not know anything about the O2 tanks in room #9 and would get someone to move them. Observation of the vestibule leading into resident room #42 on 03/18/26 at 9:18am revealed there was one 48-inch tall unsecured O2 tank in a corner. Interview with a resident on 03/18/26 at 9:18am revealed the tank was empty and belonged to the facility. Interview with the Maintenance Manager on 03/17/26 at 10:15am and 03/18/26 at 11:05am revealed: -All O2 tanks should be stored in a crate.	D 079		

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D 079	Continued From page 2 -He did not know the resident in room #9 was not storing the O2 tanks in the crate and was using the crate to store shoes. -He thought the 48-inch tank in Room #42 belonged to a durable medical equipment (DME) company and was available for emergency power outages. -The facility did not have a crate large enough to store the 48-inch O2 tank. Interview with the Administrator on 03/17/26 at 1:55pm and 03/18/26 at 11:15am revealed: -All staff were trained in proper O2 tank storage. -She did not know why staff, who entered the room multiple times a day, did not see the unsecured tanks and put them in the crate. -She had not been in room #9 recently so she did not know the tanks were not being stored properly. -The 48-inch tank in the corner of the vestibule leading into room #42 did not belong to the facility and it did not have a DME company tag on it. -The facility did not have a crate large enough to secure it. -She did not know how to dispose of the 48-inch tank since she did not know who it belonged to. Interview with a representative with the DME company on 03/18/26 at 10:04am revealed: -They provided O2 to the resident who lived in Room #9 and they provided crates for storage. -Oxygen tanks should always be stored in a crate regardless if they were empty or full. -If an oxygen tank fell over, and it still had O2 in it, it could become a projectile or the valve could become damaged and cause it to leak oxygen, a flammable substance. The facility failed to properly secure seven oxygen tanks in a crate to prevent them from	D 079		

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D 079	Continued From page 3 falling over. This failure resulted in substantial risk to residents that death or serious physical harm would occur and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/17/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 17, 2026.	D 079		
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, record reviews, and interviews, the facility failed to administer medication as ordered for 1 of 5 sampled residents (Resident #5) related to medication used to treat constipation. The findings are: Review of Resident #5's current FL2 dated 08/08/25 revealed diagnoses included diabetes, dementia, chronic lung disease and osteoarthritis. Review of Resident #5's current physician's	D 358		

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D 358	Continued From page 4 orders dated 11/12/25 revealed: -There were medication orders for senna plus 8.6-50mg 2 tablets daily. -There were medication orders for docusate sodium 100mg tablet daily as needed. Review of Resident #5's electronic medication administration record (eMAR) for 03/01/26 - 03/17/26 revealed: -There was an entry for senna plus 8.6-50mg 2 tablets daily. -There was documentation the senna plus was administered 15 times, along with 2 refusals, from 03/01/26 - 03/17/26. -There was an entry for docusate sodium 100mg tablet daily as needed. -There was no documentation the docusate sodium was administered 03/01/26 - 03/17/26. Observation of Resident #5's medications available for administration on 03/18/26 at 10:22am revealed: -There was no senna plus available for administration. -There was docusate sodium 100 mg tablets available for administration. Interview with a medication aide (MA) on 03/18/26 at 10:22am and 10:45am revealed: -Resident #5's family member bought her over the counter (OTC) medications. -A family member brought in Resident #5's OTC medications over two weeks ago which included her docusate sodium. -She was administering the docusate sodium two 100mg tablets daily for the senna plus. Interview with a pharmacist at the facility's contracted pharmacy on 03/18/26 at 10:48am revealed:	D 358		

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D 358	Continued From page 5 -Senna plus and docusate sodium were two different medications. -Senna plus was used as a stool softener and a laxative. -Docusate sodium was used as a stool softener. -The lack of taking medication without a stimulant could be concerning if the resident had problems with constipation. Interview with the Resident Care Coordinator (RCC) on 03/18/26 at 11:25am revealed: -The MAs were supposed to inform her if there was a medication missing for a resident. -She was unaware the MAs were using the docusate sodium daily for administration instead of the senna plus per the physician's orders. Telephone interview with the primary care provider (PCP) on 03/18/26 at 11:49am revealed: -The MAs should be following the physician's orders as written and contacting her if there was an issue. -She had not been contacted that docusate sodium was being given daily to Resident #5 instead of senna plus. Interview with the Administrator on 03/18/26 at 11:55am revealed: -She was not aware the MAs were substituting one medication for another for Resident #5. -The MAs were supposed to be following physician's orders for all medication administration.	D 358		

The following is the Plan of Correction for Brookdale Lenoir regarding Annual, follow up survey completed 3/18/2026. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions of 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. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

D079 - 10A NCAC 13F .0306(a)(5)

- Health and Wellness Director (HWD) re-educated residents with oxygen tanks on proper storage requirements.
- Daily walk through of the community by the HWD or designee to verify correct storage of oxygen tanks is in place.

Date of Completion: 3/19/2026

- Health and Wellness Director (HWD) re-educated staff on Oxygen Cylinders/Tanks Safe Handling according to policy.

Date completed: 3/25/2026

D358 - 10A NCAC 13F .1004(a)

- Health and Wellness Director (HWD) and Area Nurse Manager (ANM) completed an audit of medications to confirm current orders.

Date completed: 3/31/2026

- MD was notified for clarification of discrepancies.
- New Order Tracking form has been implemented and will be utilized. Health and Wellness Director (HWD)/ Resident Care Coordinator (RCC) or designee will review on a weekly basis.

Date of completion: 3/31/2026

- Med Techs will be retrained to the 6 Rights of Medication Administration by Health and Wellness Director (HWD)

Date of completion: 4/17/2026