STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060016	A. BUILDING: _____ B. WING _____	01/13/2017

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BROOKDALE CARRIAGE CLUB PROVIDENCE I	5802 OLD PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey on January 12-13, 2017.	D 000		
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, interviews, and record reviews, the facility failed to ensure physician notification for 2 of 5 sampled residents who had physician's orders for daily blood pressure monitoring with parameters for reporting (Resident #4) and lab collection every 6 months (Resident #1). The findings are: A. Review of Resident #4's current FL2 dated 10/31/16 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), cerebral vascular accident (CVA), Diabetes type 2, congestive heart failure (CHF), and dementia. -A physician's order for blood pressure (BP) checks daily, and to notify physician if the systolic BP was less than 90 or greater than 160. -A physician's order for carvedilol 12.5 mg twice a day, amlodipine 5 mg daily at bedtime, and losartan 50 mg daily at bedtime. All these medications were used to treat high blood pressure.	D 273	The following is the Plan of Correction for Brookdale Carriage Club, Assisted Living regarding the Statement of Deficiencies dated 2/3/2017. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a 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. . 10A NCAC 13F .0902(b) Health Care All residents medication orders that have parameters have been reviewed to ensure accurate transcription and documentation. . Licensed Nurses have been re-inserviced on proper procedure to transcribe orders and document vital signs. The process to be followed is as under:- LPN receives new order and transcribes to chart and MAR Second LPN checks after first LPN to ensure accuracy and completeness of order in MAR, then prints updated MAR HWD performs third and final check The Health and Wellness Director or designee will monitor and audit the received order process by performing final check, with quality assurance monthly for three months. . To assist with compliance Assisted Living Administrator or designee will review the new order process monthly for the next three months.	2/6/2017 2/6/2017 2/6/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ASSISTED LIVING DIRECTOR (X6) DATE: 2/23/2017

Reviewed and Accepted
FJW 2/23/17

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D 273	Continued From page 1 Review of the Resident Register revealed Resident # 4 was admitted to the facility on 8/28/12. Review of Resident #4's record revealed: -There was a previous physician's order dated 8/18/16 to check Resident #4's BP every day after 7:30 am and call MD if systolic BP was less than 90 or greater than 160. -There was no order after 8/18/16 to discontinue BP checks for Resident #4. Review of Resident #4's October 2016 electronic Medication Administration Record (eMAR) revealed: -An entry to check BP daily after 7:30 am. -BP readings were documented as completed daily from 10/01/16 to 10/18/16 and ranged from 130/74 to 147/63. -There were no documented BP results on the eMAR from 10/19/16 to 10/31/16. Review of Resident #4's November and December 2016 eMARs revealed: -There were no entries to check BP daily. -There were no documented BP results on the eMARs. Review of Resident #4's January 2017 eMAR on 1/12/17 revealed: -There was no entry to check BP daily. -There were no documented BP results on the eMAR. Review of Resident #4's Vital Signs (VS) log sheet revealed: -August 2016 BP results were documented daily and ranged from 126/70 to 169/65 -September 2016 BP results were documented	D 273		

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D 273	Continued From page 2 daily and ranged from 106/75 to 156/66. -October 2016 BP results were documented daily from 10/01/16 to 10/18/16 and ranged from 130/74 to 147/63. -There were no VS log sheets with documented BP results for Resident #4 from 10/19/16 to 1/12/17. Review of Resident #4's record revealed a physician visit on 1/04/17 with a BP documented as 128/70. Interview on 1/13/17 at 10:30 am with Resident #4 revealed: -She received her medications daily. -She was not able to recall the last time her BP was taken at the facility. -She could communicate her needs to the staff. -She expressed no concerns about the care that she received from the facility. Interview on 1/13/17 at 11:15 am with the facility nurse revealed: -She was a Licensed Practical Nurse (LPN). -The facility used paper MARs through 10/18/16 and began using a new eMAR system on 10/19/16. -The facility nurses were responsible for managing the MARs and eMARs. -The Personal Care Aides (PCA) or the Medication Aides (MA) obtained resident BP readings. The MA recorded the results into the eMAR system. -She could not produce any documentation that the BP checks for Resident # 4 had been documented on the eMARs from 10/19/16 through 1/12/17. -The order for Resident #4 to have BP taken daily had been entered into the "other" screen of the new eMAR system but should have been entered	D 273		

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D 273	Continued From page 3 in the "other-MAR" screen to show up on the eMARS, therefore staff were not prompted to complete daily BPs for Resident #4. -This was an entry error by the facility. -The eMARs were audited once a month by the facility nurses for accuracy. -The process for new physician orders was for the first shift facility nurse to enter the order into the eMAR system. Once it was entered, the third shift facility nurse verified the order was entered correctly. Interview on 1/13/17 at 2:00 pm with the Health Wellness Director revealed: -She was an LPN. -There was an LPN every shift. They administered medications and served as Supervisor for that shift. -They did have MAs who administered Medications when an LPN was not on duty. -The responsibility for entering orders on the eMAR belonged to the facility nurses. -The first shift nurse was to enter the physician's orders on the eMAR and the third shift nurse was to check the eMAR for accuracy. -The reason Resident #4's BP order was not correctly entered on the electronic eMAR was due to an "oversight". Refer to interview on 1/13/17 at 2:45 pm with the Administrator. B. Review of Resident #1's FL2 dated 5/13/16 revealed: -Diagnoses included, systemic lupus, kidney stones, syncope, arrhythmia, and peripheral vascular disease. -An order for a complete blood count with differential (CBC w/diff) every 6 months "(May and November)".	D 273	10 NCAC 13F .0902(b) Health Care A review has been undertaken for all residents with laboratory work orders to ensure accurate transposition. The requests have been added to the calendar on due dates. Licensed Nurses have been re-inserviced on proper procedure to transcribe lab requests and orders. The Health and Wellness Director or designee will monitor and audit the process of receiving, transcribing, checking and documenting new orders, and will perform third and final check on the process, with quality assurance monthly for three months. To assist with compliance Assisted Living Administrator or designee will review monthly for the next three months.	2/6/2017

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D 273	Continued From page 4 Review of Resident # 1's record revealed no documentation of a lab draw for a CBC w/diff for the month of November 2016, and no documentation for a lab result for a CBC w/diff for the month of November 2016. Telephone interview on 1/13/16 at 12:53 pm with Resident #1's Nurse Practitioner revealed: -The CBC w/diff was a standard lab draw. -The CBC w/diff was ordered by our physician's office on the FL2 dated 5/13/16. -She was not made aware by the facility that the CBC w/diff had not been drawn. -Labs were drawn last month, December 2016 and there was no documentation a CBC w/diff was drawn since May 2016 in the record. -She did not see the need for the CBC w/diff to be drawn since the resident was not anemic. Interview on 1/13/16 with the Health and Wellness Director (HWD) at 2:40 pm revealed: -She was a Licensed Practical Nurse (LPN). -The lab orders for the labs were written by the provider and sent to the pharmacy to be put on the electronic Medication Administration Record (eMAR). -The eMAR was to be sent to the facility and the order was taken off for the lab draw and put on the monthly calendar for contracted lab agency by one of the facility nurses. -The contracted lab agency came every Monday and Thursday and checked the monthly lab draw calendar and drew all labs listed. -There was no documentation the CBC w/diff was marked on the November 2016 lab draw calendar or that it was drawn. -Two LPNs checked the monthly calendar for accuracy.	D 273		

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D 273	Continued From page 5 Interview on 1/13/16 with Resident #1 at 3:00 pm revealed: -Her labs were drawn often to monitor her vitamin D and magnesium levels. -She also gets a CBC, sedimentation rate and a basic metabolic profile (BMP) to keep an eye on her lupus. - "I sometime request labs to keep an eye on my lupus more often than the standard" and "the doctor tells me if it is time". -She kept track of her lab results and when they were due to be drawn. -She was not aware the CBC w/diff was not drawn in November 2016. Refer to interview on 1/13/17 at 2:45 pm with the Administrator. Interview on 1/13/17 at 2:45 pm with the Administrator revealed: -The staff should clarify and follow any physician orders. -He was not aware BP checks and lab collections were not being obtained as ordered. -The nursing staff (Supervisors and HWD) were responsible to make sure physician orders were followed.	D 273		
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	D 358	10 NCAC 13F .1004(a) Medication Administration Licensed Nurses were in-serviced on 2/6/2017 on how to transcribe, document and check new orders. The process to be followed is as under:- LPN receives new order and transcribes to chart and MAR Second LPN checks after first LPN to ensure accuracy and completeness of order in MAR, then prints updated MAR The Health and Wellness Director or designee will monitor and audit the new order process by performing final check, with quality assurance monthly for three months.	2/6/2017

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D 358	Continued From page 6 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 by the physician for 1 of 5 sampled residents (Resident #2) with an order for Vitamin C 500 mg twice daily for 60 days. The findings are: Review of Resident #2's current FL2 dated 11/15/16 revealed: -Diagnoses included cellulitis, spinal stenosis, muscle weakness, abnormalities of gait and mobility, lack of coordination, dysphagia, shortness of breath, and major depressive disorder. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 11/10/16. Review of Resident #2's record revealed : -The Nurse Practitioner (NP) for the facility ordered Vitamin C 500 mg twice daily for 60 days on 11/22/16. -On 11/22/16 an order was written for a Home Health Nurse (HHN) to evaluate and treat "sore" on bottom. -The home health nurse's documention supported the wound had decreased in size since treatment started. Review of Resident #2's November and December 2016 Electronic Medication Administration Record (eMAR) revealed: -No entry for Vitamin C twice daily for 60 days on the November or December 2016 eMARs.	D 358	To assist with compliance Assisted Living Administrator or designee will review the process monthly for three months.	

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D 358	Continued From page 7 Review of Resident #2's January 2017 eMAR revealed there was no entry for Vitamin C twice daily for 60 days on the eMAR. Review of Resident #2's medications on hand on 1/13/17 at 10:00 am revealed Vitamin C was not available for administration. Interview on 1/12/17 with Resident #2 revealed: -"I have had a sore on my bottom for about a year on and off." -The resident confirmed home health provided all wound care. Interview on 1/13/17 at 10:05 am with a Medication Aide (MA) revealed: -The MA was unaware Resident #2 was ordered Vitamin C. -The MA confirmed in the eMAR that no order for Vitamin C had been entered. Interview on 1/13/17 at 11:30 am with the contracted pharmacy revealed: -The pharmacy received the initial order for Vitamin C on 11/22/16. -The pharmacy staff did not manage the facility eMAR's. -On 11/22/16 the order for Vitamin C was received and dispensed. Interview on 1/13/17 at 12:30 pm with the Health and Wellness Director revealed: -"When an order initially is written the facility nurse enters the order into the system (eMAR), then staff use a tracking form to make sure all steps were completed, and the family is notified of the new order". -The Vitamin C was never entered into the eMAR and then also missed on the tracking form. -The Health and Wellness Director was unaware	D 358		

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D 358	Continued From page 8 of a Vitamin C order and that staff never administered Vitamin C as ordered. Interview on 1/13/17 at 12: 55 pm with the Nurse Practitioner (NP) revealed: -The NP was not notified by staff that the Vitamin C had not been administered as ordered. -The NP felt no harm was done by not receiving the Vitamin C as ordered. -"The Vitamin C was initially ordered when the resident was in a Skilled Nursing Facility (SNF) prior to admission to assist with wound healing". -The NP restarted the initial order from the SNF. -The NP felt the resident received Vitamin C through the ordered Multivitamin with minerals given daily. A second interview with the Health and Wellness Director on 1/13/17 at 1:15 pm revealed: -The Health and Wellness Director called the facility NP and clarified the Vitamin C order within the last 10 minutes. -The NP discontinued Vitamin C on 1/13/17 due to resident's stage II pressure wound was healing with current Home Health treatment and resident was also receiving Vitamin C with minerals daily. Interview on 1/13/17 at 2:45 pm with the Administrator revealed the staff should clarify and follow all physician orders.	D 358		