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D 000	Initial Comments The Adult Care Licensure section conducted an annual and follow-up survey on 05/15/19-05/16/19.	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 assure referral and follow-up to meet the healthcare needs for 1 of 5 sampled residents regarding an appointment to the gastroenterologist (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 04/22/19 revealed: -Diagnoses included peripheral vascular disease, coronary artery disease, congenital malformation of the brain, and osteoarthritis. -There was a physician's order for ranitidine 150mg twice a day for gastroesophageal reflux disease (GERD). Review of Resident #1's record revealed: -Resident #1 was refusing his medications due to a vomiting incident on 02/04/19.	D 273		

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-There was no documentation Resident #1 refused his medications after 02/04/19.
-There was an order from the primary care physician (PCP) dated 02/05/19 for Resident #1 to have a speech evaluation.

Review of the Speech Therapist Visit Note report on 02/07/19 revealed:
-On 02/07/19 at 12:00pm the home health speech therapist conducted a swallowing evaluation at lunch with Resident #1.
-There were no signs or symptoms of aspiration during the meal.
-A bedside swallow assessment revealed an oropharyngeal phase due to dysphagia.
-The recommendation by the speech therapist was to refer Resident #1 to a gastroenterology (GI) team to rule out strictures or any other esophageal issue.
-The results of this swallowing evaluation and the recommendations were discussed with the previous Health and Wellness Director (HWD) and Resident #1.

Interview with the PCP's nurse on 05/16/19 at 8:25am revealed:
-The PCP had not been informed of the results of the speech therapy evaluation ordered on 02/05/19.
-The PCP had not been informed by the facility staff there was a recommendation for Resident #1 to be seen by the GI team to rule out esophageal issues.
-The PCP would have made the referral and appointment for Resident #1 to be seen by the GI team if he had been notified.

Interview with the previous HWD on 05/16/19 at 1:30pm revealed:
-She knew the PCP had ordered a speech

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evaluation for Resident #1.
-He was refusing his medications due to his concern with vomiting.
-She did not remember how often after 02/04/19 the resident refused his medications because they had received an order to crush his medications and administer them with applesauce.
-She knew there was a referral, recommended by the speech therapist post evaluation, for Resident #1 to be seen by the GI team to rule out esophageal issues.
-She thought she had contacted the responsible family member regarding this referral.
-The family member transported Resident #1 to his appointments.
-She did not follow up with the family member regarding the appointment to the GI office.
-She did not forward the results and recommendations of the speech evaluation to the PCP.
-She thought it was the responsibility of the speech therapist to follow up with the prescribing physician.

Interview with the responsible family member on 05/16/19 at 2:30pm revealed:
-She did not know the PCP had ordered a speech evaluation for Resident #1.
-She did not know the speech therapist had completed a swallow evaluation on 02/07/19.
-She did not know there was a recommendation from the swallow evaluation for Resident #1 to be seen by the GI team to rule out esophageal issues.
-She transported Resident #1 to all appointments and was the health care responsible party.
-She would have made the appointment and accompanied Resident #1 to the GI office if she had known the speech therapist recommended

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D 273	Continued From page 3 further testing. Interview with the Administrator on 05/16/19 at 3:10pm revealed: -It was the responsibility of the HWD and the clinical staff to set appointments as needed for the residents and contact the responsible family members to inform them. -The HWD should also coordinate the orders and treatments amongst the various disciplines for each resident for seamless delivery of services. -He did not know the previous HWD was not informing the physicians and responsible family members of recommendations and referrals for Resident #1. -He knew there was a breakdown in communication and accountability amongst some staff members. -It was his expectation the process and procedures would be followed for referral and follow up with physicians and family members.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

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D 338	Continued From page 4 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure dignity, respect and consideration by failing to provide food service in a timely manner. The findings are: Observation of the lunch meal on 05/15/19 from 11:50am-1:19pm revealed: -At 11:50am, several residents were sitting in the hallway awaiting entry into the dining room. -At 12:00pm, the doors were opened for residents to enter into the dining room for lunch. -From 12:00pm-12:15pm, the servers were collecting menus with resident selections, serving appetizers, and drinks to residents. -All residents who eat in the dining room were seated by 12:15pm. -There were 3 dietary servers and 2 personal care aides (PCAs) assisting with food service. -There were 39 residents seated in the dining room. -At 12:25pm, the first entree was served to a resident. -At 12:51pm, the last entree was served to a resident. Observation of the kitchen on 05/15/19 at 12:50pm revealed the interim Dietary Manager (DM) was plating the food for residents, while the servers prepared condiments and drinks for the residents. Observation of the lunch meal on 05/16/19 from 12:10pm-1:22pm revealed: -At 12:00pm, the doors were opened for residents to enter the dining room for lunch. -At 12:10pm, residents had entered the dining	D 338		

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room and were seated for lunch.
-At 12:19pm the appetizers began to be served to the residents.
-There were 3 dietary servers and 2 PCAs assisting with food service.
-There were 38 residents seated in the dining room.
-At 12:24pm, the first entree was served to a resident.
-At 12:48pm, the last entree was served to a resident.

Interview with a resident on 05/15/19 at 12:30pm revealed:
-It was taking a long time for the food to be served.
-He turned in his menu at the beginning of the week, therefore the dietary staff already know his meal request.
- "It has been this way for a while".
-He had told management n the past on various dates and nothing had been done.
-He was told "we are going to try to do better".
-The late food service happened every day, "it does not make me feel good".
-He did not complain about the temperature of his food.

Interview with 5 residents on 05/15/19 from 12:30pm-12:55pm revealed:
-It always took a long time for food to be served.
- "I don't know what the problem is".
-Complaints had been made several times in the past and nothing was done.
- "This is just terrible".
-The kitchen was understaffed most days, "it's horrendous".
-There were days residents had to wait 40-45minutes, "a lot of days".
- "It is almost 1pm, and we don't have our food

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yet".
-It took too long to get food, "it makes me upset".
-None of the residents complained about the temperature of their food once it was received.

Interview with a dietary aide on 05/16/19 at 2:06pm revealed:
-She noticed that it took a long time for residents to be served their meal.
-She did not know exactly why it took so long for residents to be served their meal.
-Residents did get upset at times and complained.
- "We do the best we can".
-There had not been any discussion with the DM or management about getting food served to residents in a timely manner.

Interview with the Interim DM on 05/16/19 at 3:40pm revealed:
-He was filling in as the DM as the manager was on medical leave.
-He realized the food service took "a long" time to be served.
-He felt the complex menu was a reason it took him so long to get food served to residents.
-Residents frequently complained in the resident council meetings regarding food being served late.
-He tried opening earlier and rearranging who gets served first and it did not help the problem.
-Management had not met together to determine ways to get residents served timely.
- "I realize it's an issue, we may need to meet to figure out what can be done".

Interview with the Administrator on 05/16/19 at 4:10pm revealed:
-He had been the Administrator for 3 months.
-He had received complaints from residents

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D 338	Continued From page 7 regarding the length of time it took for food to be served. -He was not sure why food service took so long. -He had asked the DM to hold staff accountable because they had been running late for work. -He tried to make sure staff were available and that there was enough. - "We've been piecing it together". -He had not been able to work in the dining room and observe the food service from beginning to end. -He expected residents to receive their meal timely.	D 338		
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 interviews and record reviews, the facility failed to administer medications as	D 358		

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D 358	Continued From page 8 ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (Residents #1 and #2). The finding are: Review of Resident #1's current FL-2 dated 04/22/19 revealed: -Diagnoses included peripheral vascular disease, coronary artery disease, congenital malformation of the brain and osteoarthritis. -There was a physician's order for Guar Gum powder, 1 scoop in liquid daily for constipation. Review of Resident #1's April 2019 electronic Medication Administration Record (eMAR) from 04/22/19-04/30/19 revealed: -There was an entry for Guar Gum powder to be administered daily at 8:00am. -There was no documentation the powder was administered to Resident #1. -The there was no documentation which indicated the reason the Guar Gum powder was not administered to Resident #1. Review of Resident #1's May 2019 eMAR from 05/01/19-05/15/19 revealed: -There was an entry for Guar Gum powder to be administered daily at 8:00am -There was no documentation the powder was administered to Resident #1. -The there was no documentation which indicated the reason the Guar Gum powder was not administered to Resident #1. Observation of Resident #1's medications on hand revealed the Guar Gum powder was not available for administration. Review of Resident #1's progress notes, documented by the medication aides (MAs) on	D 358		

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D 358	Continued From page 9 04/25/19, revealed the Guar Gum powder was "awaiting delivery". Interview with the Health and Wellness Director (HWD) on 05/15/19 at 3:15pm revealed: -There was a physician's order for Guam Gum powder for constipation on Resident #1's current FL2. -She entered the order on the eMAR on 04/23/19. -The pharmacy notified the facility staff on 04/25/19 they were unable to deliver the Guar Gum powder. -The powder was "a supplemental" and the pharmacy did not stock supplementals. -The Resident Care Coordinator (RCC) offered to contact the responsible family member and request they purchase the powder. -She thought the family member had brought the Guam powder into the facility for Resident #1. -She did not know the powder had not been administered to the resident for 22 days. -She did not follow up with the family member or the RCC regarding the delivery of the Guar Gum powder. -She would have contacted the prescribing physician after 2 or 3 days to discontinue the supplemental if it could not be delivered. Interview with the RCC on 05/16/19 at 11:10am revealed: -She had contacted the family member the week Resident #1 arrived back to the facility (04/23/19) to purchase the Guar Gum powder. -She thought the family member had brought the Guar Gum powder to the facility. -The MAs did not let her know the powder was not on the medication cart. -She relied on the MAs to report when a medication entered on the eMAR was not in the facility.	D 358		

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D 358	Continued From page 10 -She did not follow up with the family member to determine whether they had brought the supplement to the facility. -She and another nurse were responsible for cart audits on the medication carts. -They tried to perform one cart audit a week, so all 4 medication carts would be completed in one month. -She had last completed a cart audit in late March; "It has been very busy." Interview with the nurse at the prescribing physician's office on 05/16/19 at 8:25am revealed: -The Guar Gum powder was prescribed for constipation on a hospital discharge summary dated 04/08/19. -The physician continued the prescription based on the hospital discharge orders. Interview with the responsible family member on 05/16/19 at 2:30pm revealed: -She had been contacted by the facility to locate Guar Gum powder commercially since the pharmacy did not stock supplementals. -She had located the powder online but was told by the MA the powder could only be administered by them if each serving was individually packaged. -She could not find individually packaged servings of Guar Gum powder. Interview with the facility's contracted pharmacist on 05/15/19 at 4:30pm revealed: -On 04/25/19, the facility staff faxed Resident #1's current FL2 dated 04/22/19. -The pharmacy staff person contacted the facility on 04/25/19 and reported they could not fill the Guar Gum powder as ordered for constipation. -The pharmacy did not stock supplementals.	D 358		

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D 358	Continued From page 11 Review of the Medications and Treatments Availability Policy revealed: -It was 'the facility's policy that all currently ordered medications will be available to the residents'. -'The Community is responsible for obtaining newly ordered medications or refills for medications and treatment orders... in accordance with the Pharmacy Services Agreement Addendum to the Residency Agreement.' Interview with the Administrator on 05/16/19 at 3:10pm revealed: -He did not know Resident #1 had been prescribed a scheduled medication for constipation on 04/23/19 which was not administered for 22 days. -He relied on the clinical staff to oversee the medications and assure orders were filled as prescribed by the physicians. -Medication orders should be filled in a timely manner, within a few days "at the most". 2. Review of Resident #2's FL2 dated 02/27/19 revealed: -Diagnoses included lordosis, prolapsed bladder, osteoporosis with fractures and cardiac stents. -There was an order for senna 8.5-50mg one tablet every 12 hours, hold for loose stools. There was a subsequent physician's order dated 05/02/19 for senna 8.6-50mg, two tablets to be administered on Tuesday and Thursday. Review of a telephone order from the primary care physician (PCP) dated 05/06/19 revealed: -The PCP discontinued the scheduled dose of senna 8.6-50mg on Tuesdays and Thursdays per	D 358		

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the family's request.
-The new order was senna 8/6-50mg, two tablets per day as needed for constipation.
-The order was signed as received by the Resident Care Coordinator (RCC).

Review of the May 2019 electronic medication administration record from 05/06/19-05/16/19 revealed:
-There was an entry for senna 8.6-50mg 2 tablets to be administered on Tuesday and Thursday.
-There was documentation senna, 2 tablets, was administered on 05/07/19, 05/14/19 and 05/16/19 as a scheduled medication.
-There was no entry to discontinue senna 8.6-50mg, two tablets, to be administered on Tuesday and Thursday.
-There was no entry for senna 8.6-50mg, two tablets, to be administered once a day as needed (PRN) for constipation.

Interview with the RCC on 05/16/19 at 3:31pm revealed:
-The New Order Tracking form was to be completed for all new orders for the residents.
-She would sign and date the New Order Tracking form when she received the order from the physician.
-She contacted the responsible party and informed them of the resident's new order.
-She faxed the order to the pharmacy and verified the pharmacy received the order by telephone.
-She would transcribe the order onto the eMAR system.
-A copy of the order would be placed in the resident's chart.
-The original order with the Tracking Form was placed in the New Order Tracking notebook and flagged until the Health and Wellness Director (HWD) reviewed and co-signed, and the

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D 358	Continued From page 13 medication arrived in the facility. -She did not know why she signed the New Order Tracking form for Resident #2's senna order and did not follow the process for new orders. -She did not know why she had not transcribed Resident #2's senna 8.6-50mg, 2 tablets once a day, PRN order onto the eMAR. -'There has been a lot going on this past month and I do not remember why I did not enter the senna order for Resident #2 onto the eMAR. -She did not know why the New Order Tracking form had been filed in Resident #2's record without a copy in the New Order Tracking binder. -She did not know why she had not faxed the senna order to the pharmacy. -"I guess someone took the New Order Tracking form from the binder and filed it into Resident #2's record." Interview with the HWD on 05/15/19 at 3:15pm revealed: -The New Order Tracking form was to be completed by any of the 3 nurses who received an order by phone, fax or brought to the nurses station after a physician's visit. -The New Order Tracking Form had several steps to be followed in the processing of new orders. -Each step was to be initialed and dated by the person who completed the task. -The new order was left flagged in the New Order binder for her review . -Once she had verified the order, it was entered on the eMARs and the medication was received in the facility, the New Tracking Form was filed in the resident's record. -She did not know there was an order for Resident #2 to change the scheduled senna 8.6-50mg 2 tablets on Tuesday and Thursday to a PRN medication, once daily.	D 358		

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 _____	R 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CARRIAGE CLUB PROVIDENCE	5802 OLD PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 358	Continued From page 14 -She did not have a copy of this order in the New Order Tracking binder. -She did not know why the RCC did not follow the facility process for New Order Tracking. Interview with the prescribing physician on 05/16/19 at 12:00pm revealed: -She had changed the senna order for Resident #2 from a scheduled daily administration to a PRN administration per the family's request on 05/06/19. -She expected the facility to follow the orders she prescribed for the residents. Interview with Resident #2 on 05/16/19 at 2:55pm revealed: -She had refused the senna medication since she was not constipated. -She was concerned she would have diarrhea if she continued to take the senna daily. -She requested the senna to be administered as she needed it for constipation. -She had not experienced any constipation recently. Interview with the Administrator on 05/16/19 at 3:10pm revealed: -He did not know the RCC had not followed the process for Tracking New Orders for Resident #2's medication. -He knew there was a breakdown in communication and accountability amongst some staff members. -It was his expectation the process and procedures would be followed for physician orders and medication administration.	D 358		