STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060101	A. BUILDING: _____ B. WING _____	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SOUTH CHARLOTTE	5515 REA ROAD CHARLOTTE, NC 28226

(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 and the Mecklenburg County Department of Social Services conducted an annual survey on 03/22/22- 03/23/22.	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, with an order for daily blood pressure readings, and a medication that required blood pressure and heart rate monitoring before administering (Resident #3). The findings are: Review of Resident #3's current FL2 dated 02/14/22 revealed: -Diagnoses included hypertensive heart disorder, coronary artery disease (CAD) and chronic kidney disease (CKD). -There was an order dated 02/21/22 for Atenolol 50mg, (used to control high blood pressure), to be administered twice a day. Review of Resident #3's physician's order summary report dated 02/21/22 revealed:	D 276		

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D 276	Continued From page 1 -There was an order for Atenolol 50mg to be administered twice a day, and a handwritten notation to the side of the order, to hold for systolic blood pressure less than 110 or heart rate less than 50. -The order with parameters was on page 2 of the summary report. Review of Resident #3's February 2022 electronic Medication Administration Record (eMAR), from 02/21/222 through 02/28/22 revealed: -There was an entry dated 02/21/22 for Atenolol twice daily, to be administered at 8:00am and 8:00pm. -There was documentation Atenolol was administered twice daily from 02/21/222 through 02/28/22 at 8:00am and 8:00pm. -There was no entry for the Atenolol to be held if the systolic blood pressure was less than 110 or the heart rate less than 50. -There was no documentation blood pressure or heart rate was taken daily. Review of Resident #3's March 2022 eMAR, from 03/01/22 through 03/23/22 revealed: -There was an entry dated 02/21/22 for Atenolol twice daily, to be administered at 8:00am and 8:00pm. -There was documentation Atenolol was administered twice daily from 03/01/222 through 03/23/22 at 8:00am and 8:00pm. -There was no entry for the Atenolol to be held if the systolic blood pressure was less than 110 or the heart rate less than 50. -There was no documentation blood pressure or heart rate was taken daily. Telephone interview with a representative from the facility's contracted pharmacy on 03/23/21 at 3:13pm revealed:	D 276		

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-Resident #3 was a new admission and her FL2 dated 02/21/22 was faxed to the pharmacy.
-There was a physician's order summary that was also faxed, but page 2 of the summary was missing.
-If Atenolol was administered with systolic blood pressure less than 110 or heart rate less than 50, the resident could experience a drop in blood pressure (hypotension) or bradycardia (slow heart rate).

-Interview with the Resident Care Coordinator (RCC) on 03/22/22 at 2:15pm revealed:
-The Health and Wellness Director (HWD) faxed Resident #3's FL2 and order report summary to the pharmacy on 02/21/22.
-The HWD entered Resident #3's medications on the eMARs.
-She did not go behind the HWD to ensure accuracy when orders were entered on the eMARs.
-She did not know if the HWD reviewed the orders she entered for accuracy.
-She thought at one time a Regional Registered Nurse (RN) had stated that best practice was to have another staff verify order entry on the eMAR to ensure accuracy.
-However, she and the HWD did not follow those guidelines at all times.
-She did not know the order for Resident #3's Atenolol included parameters, to hold if the systolic blood pressure was less than 110 or the heart rate less than 50.
-If she knew, she would have clarified the handwritten orders with the physician.

Interview with the facility's Regional Clinical Specialist on 03/23/22 at 11:18am and 2:15pm revealed:
-The Health and Wellness Director (HWD) was

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responsible for reviewing the resident's FL2's, faxing the FL2 to the pharmacy and entering the orders onto the eMAR.
-The HWD could delegate this task to the RCC.
-Processing new orders should be enacted within 24 hrs of receiving them.
-If the HWD puts the order on the eMAR then the RCC should verify that the order was entered correctly.
-If the RCC entered the order then the HWD should verify that it was entered correctly.
-Best practice, there should be a 2 person check system when orders were entered onto the eMARs.
-The second person would activate the order after it was reviewed for accuracy.
-The pharmacy did not enter physician orders onto the eMAR.
-Physician order summary reports were sent to the physician to ensure no orders were left off and that an order was entered on the eMAR correctly.
-The summary report was then sent to the pharmacy.
-She was not aware that an order for daily blood pressure monitoring before a blood pressure medication was administered had not been entered on the eMAR.
-The handwritten order on the physician summary report should have been clarified with the physician and added to the eMAR entry.
-The HWD and RCC should regularly audit all resident's records.

Interview with the Administrator on 03/23/22 at 3:48pm revealed:
-The HWD and RCC were responsible for all clinical policies and procedures.
-He expected the clinical team to correctly transcribe orders onto the eMAR and fax all

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D 276	Continued From page 4 necessary paperwork to the pharmacy so that residents were administered medications as prescribed by their physician. -The order summary report should have been clarified by the HWD and entered onto the eMARs for the proper administration of Atenolol. -He did not know Resident #3 did not have her blood pressure and heart rate monitored daily. Attempted telephone interview with Resident #3's primary care provider (PCP) on 03/23/22 at 1:07pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	D 276		
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 ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (#3) related to medications used to treat an infection. The findings are:	D 358		

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Review of Resident #3's current FL2 dated 02/14/22 revealed diagnoses included hypertensive heart disorder; coronary artery disease (CAD) and chronic kidney disease (CKD).

Review of the facility medication policy dated 12/17, all currently ordered medications will be available to the resident.

a. Resident #3's physician's order dated 03/11/22 revealed there was an order for Flagyl 500mg, to be administered three times a day for 10 days, sent electronically to the facility's contracted pharmacy.

Review of Resident #3's March 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry dated 03/15/22 for Flagyl three times daily for 10 days, administered at 9:00am, 2:00pm, and 6:00pm.
-There was documentation Flagyl was administered three times daily from 03/15/22 through 03/21/22 , and at 9:00am on 03/22/22.
-There was documentation Flagyl had not been administered on 03/22/22 at 2:00pm and 6:00pm, and on 03/23/22 and 03/24/22 at 9:00am, 2:00pm or 6:00pm.
-Seven of the thirty doses of Flagyl were not administered to Resident #3.

Telephone interview with a representative from the facility's contracted pharmacy on 03/23/21 at 2:09pm revealed:
-Resident #3's primary care physician (PCP) sent on electronic prescription on 03/11/22 for Flagyl 500mg three times a day for ten days.
-Flagyl was filled and dispensed to the facility on 03/12/22, with a total of 30 pills.

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-The pharmacy staff did not enter physician orders onto the eMARs.
-If the Flagyl was not taken as prescribed by the physician, the resident could experience a recurring infection.

Interview with the Resident Care Coordinator (RCC) at 03/22/22 at 2:15pm revealed she did not know seven of thirty doses of Flagyl were not administered to Resident #3.

Interview with the facility's Regional Clinical Specialist on 03/23/22 at 11:18am revealed she did not know seven of thirty doses of Flagyl were not administered to Resident #3.

Interview with the Administrator on 03/23/22 at 4:01pm revealed he did not know seven of thirty doses of Flagyl were not administered to Resident #3.

Refer to interview with the RCC at 03/22/22 at 2:15pm.

Refer to interview with the Regional Clinical Specialist on 03/23/22 at 11:18am.

Refer to interview with the Administrator on 03/23/22 at 3:48pm.

Attempted telephone interview with the PCP on 03/23/22 at 1:07pm was unsuccessful.

b. Resident #3's physician's order dated 03/12/22 revealed there was an order for Cefdinir 300mg to be administered every evening for 10 days.

Review of Resident #3's electronic Medication Administration Record (eMAR) for revealed:
-There was an entry dated 03/14/22 for Cefdinir

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300mg, once daily in the evening for 10 days, to be administered at 8:00pm.
-There was documentation Cefdinir was administered on 03/14/22 through 03/21/22 at 8:00pm.
-There was no documentation Cefdinir had been administered on 03/22/22 or 03/23/22.
-Two of the ten doses of Cefdinir were not administered to Resident #3.

Telephone interview with a representative from the facility's contracted pharmacy on 03/23/21 at 2:09pm revealed:
-There was a physician order for Resident #3, faxed from the facility on 03/12/22, for Cefdinir 300mg to be administered in the evening for 10 days.
-Cefdinir was filled and dispensed to the facility on 03/12/22 with a total of 10 pills.
-The pharmacy staff did not enter physician orders onto the eMARs.
-If the Cefdinir was not administered as prescribed by the physician, the resident could experience a recurring infection.

Interview with the Resident Care Coordinator on 03/22/22 at 2:15pm revealed she did not know two of the ten doses of Cefdinir were not administered to Resident #3.

Interview with the facility's Regional Clinical Specialist on 03/23/22 at 11:18am revealed she did not know two of the ten doses of Cefdinir were not administered to Resident #3.

Refer to interview with the RCC on 03/22/22 at 2:15pm.

Refer to interview with the Regional Clinical Specialist on 03/23/22 at 11:18am.

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D 358	Continued From page 8 Refer to Interview with the Administrator on 03/23/22 at 4:01pm revealed he did not know two of the ten doses of Cefdinir were not administered to Resident #3. Attempted telephone interview with the PCP on 03/23/22 at 1:07pm was unsuccessful. _____ Interview with the Resident Care Coordinator (RCC) on 03/223/22 at 2:15pm revealed: -Physician orders were processed by the Health and Wellness Director (HWD) or the RCC. -Orders were received from the in house physician during weekly rounds or by fax. -Orders from external physicians were left with the Concierge on the first floor and delivered to the medication room to be faxed. -The HWD, RCC or medication aides (MAs) could fax orders to the pharmacy. -The HWD or RCC entered orders onto the eMARs. -The pharmacy usually sent the medication to the facility within 24 hours or less. -The MAs were alerted to new orders through the "Hot Box" communication board in the medication room and the shift report from the previous shift. -The HWD reviewed the medication orders entered on the eMAR for accuracy. -She did not review the eMARs to ensure there were no missed medications. -She was not aware of any report the HWD ran for missed medications. -She did not know why the medications were not administered as ordered. Interview with the Regional Clinical Specialist on 03/23/22 at 11:18am revealed: -The previous Health and Wellness Director (HWD) left her position 03/18/22 and she was	D 358		

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assisting the facility in the interim.
-The HWD was responsible for entering new orders onto the electronic medication administration record (eMAR).
-She was also responsible for reviewing the resident's FL2's, fax the FL2 to the pharmacy and enter the orders onto the eMAR.
-The pharmacy did not enter physician orders onto the eMAR.
-Best practice, there should be a 2 person check system when orders were entered onto the eMARs.
-The second person would activate the order after it was reviewed for accuracy.
-The new order will flash "yellow" to alert the medication aide (MA) the order was new and trigger them to look for the medication.
-The MAs also documented new medication orders on the facility's shift report sheet to alert the next shift.
-If the MA was not able to locate the new medication, they would contact the pharmacy and the Resident Care Coordinator (RCC).
-She was not aware of any report the HWD ran for missed medications.
-She did not know why the medications were not administered as ordered.

Interview with the Administrator on 03/23/22 at 4:01pm revealed:
-The HWD and RCC were responsible for all clinical policies and procedures.
-He did not provide oversight to the HWD and RCC in clinical matters since he did not have a medical background.
-He referred all clinical matters that needed to be elevated to the Regional Clinical Specialist.
-The Regional Clinical Specialist was currently in the facility assisting the RCC until a new HWD was hired.

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