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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-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:

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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		