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 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CARRIAGE CLUB PROVIDENCE I	5802 OLD PROVIDENCE 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 completed a follow-up visit and complaint investigation on from September 23, 2025 to September 24, 2025.	{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 interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 1 of 5 sampled residents (#3) related to not notifying the pharmacy and the provider when a medication used to treat high cholesterol and a vitamin deficiency was not delivered to the facility after they were re-ordered. The Finding are: Review of Resident #3's current FL2 dated 08/07/25 revealed diagnoses included general weakness and cognitive impairment. Review of Resident Register revealed Resident #3 was admitted on 05/09/25. a. Review of Resident #3's current FL2 dated 08/07/25 revealed there was an order for atorvastatin calcium (a medication to treat high cholesterol)10mg daily. Review of Resident #3's September 2025 electronic Medication Administration Record (eMAR) revealed there was an entry for	D 273		

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atorvastatin calcium 10mg daily documented as not administered 09/19/25 to 09/23/25 at 8:00am.

Observation of Resident #3's medications on hand on 09/23/25 at 4:00pm revealed there was no atorvastatin calcium 10mg available for administration.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/23/25 at 4:34pm revealed:
-On 08/12/25, the pharmacy received Resident #3's current FL2 dated 08/07/25.
-There was an order for atorvastatin calcium 10mg daily and on 08/20/25, twenty-nine tablets (a 29-day supply) were dispensed to the facility.
-The medication orders on Resident #3's current FL2 dated 08/07/25 did not contain any refills.
-There were no additional signed physician's orders to allow refills for the atorvastatin after 08/07/25.
-The atorvastatin was used to lower the "bad" cholesterol and increase the "good" cholesterol in the body.
-Five missed doses of Atorvastatin would have to check the blood work to see if there was a concern for Resident #3.

Interview with the HWD on 09/24/25 at 9:15am revealed:
-On 09/16/25, a MA sent a refill request to the pharmacy for Resident #3's atorvastatin but she was not notified.
-The MA that sent the refill request for Resident #3's atorvastatin on 09/16/25 was an agency MA.
-She was responsible to call the pharmacy when Resident #3's atorvastatin did not come in after it was reordered on 09/16/25 or 09/17/25.
-Because she was not notified there was a reorder requested for Resident #3's atorvastatin,

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she did not follow-up with the pharmacy to see what the issue was.
-She did not know Resident #3's atorvastatin needed a new order with refills and then she would have been responsible for following-up with Resident #3 Primary Care Physician for new orders and to let the PCP know Resident #3 had been without the atorvastatin.

Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 09/23/25 at 4:34pm.

Refer to interview with a medication aide on 09/23/25 at 4:00pm.

Refer to interview with the Health and Wellness Director (HWD) on 09/24/25 at 4:13pm.

Refer to interview with the Administrator on 09/24/25 at 9:15am.

b. Review of Resident #3's current FL2 dated 08/07/25 revealed there was an order for cyanocobalamin (a vitamin D supplement)1000mcg daily.

Review of Resident #3's September 2025 eMAR revealed there was an entry for cyanocobalamin 1000mcg daily documented as not administered 09/22/25 and 09/23/25 at 8:00am.

Observation of Resident #3's medications on hand on 09/23/25 at 4:00pm revealed there was no cyanocobalamin 1000mcg available for administration.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/23/25 revealed:

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-There was an order for cyanocobalamin 1000mcg daily and on 08/12/25, thirty tablets (a 30-day supply) were dispensed to the facility.
-The medication orders on Resident #3's current FL2 dated 08/07/25 did not contain any refills.
-There were no additional signed physician's orders to allow refills for the cyanocobalamin after 08/07/25.
-The cyanocobalamin was used to replace vitamin B12 deficiency which would cause the body to show signs of muscle weakness.
-Three missed doses of cyanocobalamin would probably not impact Resident #3's muscle weakness.

Interview with the HWD on 09/24/25 at 9:15am revealed:
-The MA that sent the refill request for Resident #3's cyanocobalamin on 09/22/25 was an agency MA.
-She was responsible to call the pharmacy when Resident #3's cyanocobalamin did not come in after it was reordered cyanocobalamin on 09/22/23 or 09/23/25.
-Because she was not notified there was a reorder requested for Resident #3's cyanocobalamin, she did not follow-up with the pharmacy to see what the issue was.
-She did not know Resident #3's cyanocobalamin needed a new order with refills and then she would have been responsible for following-up with Resident #3 Primary Care Physician for new orders and to let the PCP know Resident #3 had been without the cyanocobalamin.

Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 09/23/25 at 4:34pm.

Refer to interview with a medication aide on

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D 273	Continued From page 4 09/23/25 at 4:00pm. Refer to interview with the Health and Wellness Director (HWD) on 09/24/25 at 4:13pm. Refer to interview with the Administrator on 09/24/25 at 9:15am. _____ Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/23/25 at 4:34pm revealed: -It was the facility's responsibility to contact the physician for new orders with refills. -It was also the facility's responsibility to contact the pharmacy when the medications did not arrive at the facility to be administered to Resident #3. Interview with a medication aide on 09/23/25 at 4:00pm revealed: -Typically, she would press the refill button on the eMAR but someone had already re-ordered the medications. -She looked in the medication cart for the medications and in the overstock and the medications were not there, so she documented as not administered. -She did not let the Health and Wellness Director know the medications were out. -She was not directed to do anything else when she started working at the facility. Interview with the HWD on 09/24/25 at 9:15am revealed: -The MAs were responsible to re-order Resident #3's medications and notify her. -She was having trouble with agency MAs notifying her about medications that were not available for administration.	D 273		

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D 273	Continued From page 5 Interview with the Administrator on 09/24/25 at 9:15am revealed: -The MAs were responsible to reorder medications before the resident ran out and notify the HWD. -The HWD was responsible to call the pharmacy to follow-up if a resident's medication did not arrive from the pharmacy and was not available to be administered to the resident. Attempted telephone interview with Resident #3 PCP on 09/2425 at 9:35am was unsuccessful.	D 273		