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 _____	R-C 10/18/2024

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 and follow-up survey on 10/16/24-10/18/24.	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 notify the primary care provider (PCP) related to 1 of 5 sampled residents (#2) who had elevated finger stick blood sugars (FSBS). The findings are: Review of Resident #2's most recent FL2 dated 09/26/23 revealed diagnoses included diabetes, history of cerebrovascular accident, hypertension and stage 3 chronic kidney disease. Review of Resident #2's physician's orders dated 06/14/24 revealed an order for FSBS checks twice a day and to call the PCP if the evening reading was greater than 200. Review of Resident #2's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks twice a day with a parameter to call the PCP if the evening reading was greater than 200. -There was documentation the evening FSBS was elevated 15 of 31 readings.	D 273		

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D 273	Continued From page 1 Review of Resident #2's September 2024 eMAR revealed: -There was an entry for FSBS checks twice a day with a parameter to call the PCP if the evening reading was greater than 200. -There was documentation the evening FSBS was elevated 8 of 30 readings. Review of Resident #2's October 2024 eMAR revealed: -There was an entry for FSBS checks twice a day with a parameter to call the PCP if the evening reading was greater than 200. -There was documentation the evening FSBS was elevated 5 of 15 readings. Review of Resident #2's August 2024, September 2024 and October 2024 progress notes revealed there were no entries documenting the PCP was notified of FSBSs greater than 200. Interview with Resident #2's PCP's medical assistant on 10/17/24 at 9:56am revealed: -Resident #2 received FSBS checks due to her diagnosis of diabetes. -Resident #2 was seen regularly in the office and they were aware of her elevated evening FSBS readings because the family member who brought her provided a record. -There was no record anyone from the facility contacted them when the evening FSBS reading was over 200. -The PCP would expect to be notified if the evening FSBS reading was greater than 200. Interview with a medication aide (MA) on 09/17/24 at 4:36pm revealed: -She never called the PCP when Resident #2 had an elevated FSBS reading because it was after	D 273		

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D 273	Continued From page 2 hours and no one would be at the PCP's office. -She was never trained or asked her supervisor how to contact a PCP in the evening. Attempted interview with a second MA on 10/18/24 at 10:18am was unsuccessful. Interview with the interim Health and Wellness Director (HWD) on 10/17/24 at 11:07am revealed: -She was not aware the MAs were not contacting the PCP when Resident #2 had FSBS readings over 200. -The MA should have asked her or the previous HWD if they did not know how to contact a PCP after hours. Interview with the Administrator on 10/17/24 at 11:07am revealed: -She was not aware the PCP was not being contacted about elevated FSBS reading. -She expected the MA to follow the PCP's orders. -The MA should have asked the HWD if they did not know how to contact a PCP after hours.	D 273		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	D 367		

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D 367	Continued From page 3	D 367		

documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 5 sampled residents (#2) related to a medication to treat elevated blood pressure.

The findings are:

Review of Resident #2's most recent FL2 dated 09/26/23 revealed diagnoses included diabetes, history of cerebrovascular accident, hypertension and chronic kidney disease.

Review of Resident #2's physician's orders dated 06/14/24 revealed:
-An order for blood pressure checks twice daily.
-An order for Chlorthalidone (used to treat elevated blood pressure) 25mg as needed if systolic blood pressure is greater than 150mm or diastolic blood pressure is greater than 100mm.

Review of Resident #2's August 2024 eMAR revealed:
-There was an entry for blood pressure checks twice daily.
-There was an entry for Chlorthalidone 25mg as needed for systolic blood pressure greater than 150mm or diastolic blood pressure greater than

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D 367	Continued From page 4	D 367		

100mm.
-There was documentation Resident #2's systolic blood pressure was greater than 150mm on 08/01/24 through 08/04/24, 08/06/24, 08/09/24, 08/12/24, 08/13/24, 08/15/24, 08/17/24 through 08/19/24, 08/23/24, 08/24/24, 08/26/24, 08/30/24 and 08/31/24 and there was no documentation Chlorthalidone 25mg was administered on those days.

Review of Resident #2's September 2024 eMAR revealed:
-There was an entry for blood pressure checks twice daily.
-There was an entry for Chlorthalidone 25mg as needed for systolic blood pressure greater than 150mm or diastolic blood pressure greater than 100mm.
-There was documentation Resident #2's systolic blood pressure was greater than 150mm on 09/01/24, 09/03/24, 09/05/24 through 09/07/24, 09/11/24, 09/12/24, 09/14/24, 09/15/24, 09/21/24, 09/23/24, 09/25/24 and 09/29/24 and there was no documentation Chlorthalidone 25mg was administered on those days.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for blood pressure checks twice daily.
-There was an entry for Chlorthalidone 25mg as needed for systolic blood pressure greater than 150mm or diastolic blood pressure greater than 100mm.
-There was documentation Resident #2's systolic blood pressure was greater than 150mm on 10/04/24, 10/08/24, 10/11/24, 10/14/24 and 10/15/24 and there was no documentation Chlorthalidone 25mg was administered on those days.

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D 367	Continued From page 5 Review of the facility's Medication Policy dated May 2005 revealed all medications administered on an as needed basis are to be recorded promptly on the eMAR documenting the reason the medication was administered and the effect of the medication. Observation of medications on hand on 10/17/24 at 11:05am revealed Chlorthalidone 25mg was available for administration. Interview with a medication aide (MA) on 09/17/24 at 11:00am revealed: -Resident #2 had an order for blood pressure checked twice a day and if the systolic reading was greater than 150mm she had an order for Chlorthalidone. -There was a place on Resident #2's eMAR to document blood pressure and administration of Chlorthalidone. -She did not know why she did not document the administration of the Chlorthalidone. Interview with a second MA on 10/17/24 at 4:36pm revealed: -She worked 2nd shift and Resident #2 had an order for her blood pressure to be checked in the evening and if the systolic reading was greater than 150mm she had an order for Chlorthalidone. -There was a place on Resident #2's eMAR to document blood pressure and administration of Chlorthalidone. -She did not know why she did not document the administration of the Chlorthalidone but she knew she always administered it. Interview with Resident #2's private sitter on 10/18/24 at 8:15am revealed: -The MAs took Resident #2's blood pressure	D 367		

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D 367	Continued From page 6 every day and told her what the reading was. -Chlorthalidone was always administered if Resident #2's blood pressure was elevated. -She documented everything on a paper that Resident #2's family member collected. Interview with Resident #2's family member on 10/18/24 at 10:24am revealed: -The sitter documented all blood pressure readings and all Chlorthalidone administration on a paper kept in Resident #2's room. -She collected the papers weekly and reviewed them. -Chlorthalidone was always administered when blood pressures were elevated. Interview with the interim Health and Wellness Director on 10/17/24 at 11:07am revealed: -All MAs were trained to document medication administration and did not know why they were not doing it properly. -She never audited the eMARs other than reviewing missed doses and as needed medications did not show up as a missed medication. Interview with the Administrator on 10/17/24 at 11:07am revealed: -She expected the MAs, who were trained, to properly document medication administration. -Nobody was responsible for auditing eMARs for missed medications that were only administered on an as needed basis.	D 367		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents	D 451		

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D 451	Continued From page 7	D 451		

(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services (DSS) for incidents involving 2 of 5 sampled residents (Resident #4 and #5) who received injuries that required emergency medical treatment.

The findings are:

1. Review of Resident #4's current FL2 dated 11/09/23 revealed diagnoses included cerebral infarction, hypertension, atrial fibrillation, and congestive heart failure.

Review of Resident #4's Resident Register revealed an admission date of 06/22/22.

Review of Resident #4's emergency department (ED) discharge summary dated 08/14/24 revealed:
-Resident #4 visited the ED after a fall.
-Resident #4 was diagnosed with initial encounters for fall, closed head injury, and cervical myofascial strain (a disorder in which pressure on sensitive points in the muscles causes pain in seemingly unrelated body parts).

Interview with the Interim Health and Wellness

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D 451	Continued From page 8	D 451		

Director (HWD) on 10/16/24 at 4:16pm revealed:
-There was no incident report completed for Resident #4's fall on 08/14/24.
-The incident was not reported to the local county DSS.

Interview with the Adult Home Specialist (AHS) on 10/17/24 at 3:00pm revealed the facility did not send an incident report regarding Resident #4's fall and ED evaluation on 08/14/24.

Interview with the Administrator on 10/17/24 at 4:25pm revealed:
-The medication aides (MAs) were responsible for documenting information about incidents and accidents into the facility's electronic documentation system.
-The HWD would use the information entered by the MAs to complete incident reports.
-The HWD was responsible for sending completed incident reports to the local county DSS.
-The interim HWD was responsible for HWD duties until a new HWD was hired.
-The interim HWD failed to complete an incident report on Resident #4's fall and ED evaluation on 08/14/24.
-The interim HWD failed to notify the local county DSS about the incident involving Resident #4 on 08/14/24.

2. Review of Resident #5's current FL2 dated 12/28/23 revealed diagnoses included dementia, major depressive disorder, anxiety, hypertension, ostepenia (low bone density), and macular degeneration.

Review of Resident #5's Resident Register revealed an admission date of 12/29/22.

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D 451	Continued From page 9	D 451		

Review of Resident #5's local emergency department (ED) discharge summary report dated 10/06/24 revealed:
-Resident #5 was seen for a fall.
-Resident #5 was diagnosed with a right wrist fracture.

Interview with the interim Health and Wellness Director (HWD) on 10/16/24 at 4:15pm revealed:
-Resident #5 fell on 10/06/24 at 1:00pm on her right knee and right wrist and was sent to the ED for an evaluation.
-The medication aide (MA) documented the details of the fall on the facility's internal computer system.
-She was notified on 10/07/24 that Resident #5 fell on 10/06/24 and was sent to the ED.
-She was responsible for filling out an Incident and Accident (I&A) Report and faxing it to the local county Department of Social Services (DSS) which she "failed" to fill out the I&A report or send a copy to DSS.

Interview with the Adult Home Specialist (AHS) on 10/17/24 at 12:00pm revealed the facility did not send an I&A report regarding Resident #5's fall and ED evaluation on 10/06/24.

Interview with the Administrator on 10/18/24 at 10:00am revealed:
-The MAs were responsible for documenting information about incidents and accidents into the facility's internal computer system.
-The HWD would use the information entered by the MAs to complete I&A reports.
-The HWD was responsible for sending completed I&A reports to the local county DSS.
-The interim HWD failed to complete an I&A report for Resident #5's fall and ED evaluation on 10/06//24.

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D 451	Continued From page 10 -The interim HWD failed to notify the local county DSS within 48 hours after Resident #5's fall requiring an ED evaluation on 10/06/24.	D 451		