

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL036015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/17/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE ROBINWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1750 ROBINWOOD ROAD</b> <b>GASTONIA, NC 28054</b>
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(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}	<p>Initial Comments</p> <p>The Adult Care Licensure Section and Gaston County Department of Social Services conducted a follow-up survey on 09/17/25.</p>	{D 000}		
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p> <p>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 routine healthcare needs for 1 of 5 sampled residents (#2) related to notifying the Primary Care Physician (PCP) for systolic blood pressure readings of 110 or less and/or pulse less than 60.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL2 dated 09/30/24 revealed diagnoses included hypertension (high blood pressure). -There was an order for amlodipine (a medication to lower blood pressure) 5mg one tablet daily. -The order indicated there were parameters for the medication.</p> <p>Review of Resident #2's signed physician's orders dated 04/17/25 revealed: -There was an order for amlodipine 5mg one tablet daily. -Amlodipine 5mg was to be held for systolic blood pressure of 110 or less and/or pulse less than 60 and staff were to contact the PCP.</p>	D 273		

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D 273	<p>Continued From page 1</p> <p>Review of Resident #2's August electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for amlodipine 5mg one tablet daily, hold for systolic blood pressure less than 110 and/or pulse less than 60 and notify the PCP.</li> <li>-There were 5 of 31 opportunities documented on the amlodipine 5 mg entry when Resident #2's systolic blood pressure was less than 110.</li> <li>-For example, on 08/09/25 at 9am Resident #2's blood pressure was 96/56.</li> <li>-There was 1 of 31 opportunities documented on the amlodipine 5mg entry when Resident #2's pulse was less than 60.</li> <li>-For example on 08/31/25 at 9am, Resident #2's pulse was 59.</li> </ul> <p>Review of Resident #2's record revealed there was no documentation her PCP was notified when her systolic blood pressure was 110 or less or her pulse was less than 60.</p> <p>Interview with a medication aide (MA) on 09/17/25 at 5:05pm revealed:</p> <ul style="list-style-type: none"> <li>-The MAs were responsible to check Resident #2's blood pressure and pulse and to notify her PCP if the systolic blood pressure and/or pulse was outside of the ordered parameters.</li> <li>-The MAs were responsible for documenting PCP notifications of systolic blood pressure and/or pulse in the Resident #2's progress notes located in the electronic documentation system.</li> <li>-She did not know if Resident #2's PCP was notified when her systolic blood pressure and/or pulse that were out of ordered parameters.</li> </ul> <p>Interview with the Health and Wellness Director (HWD) on 09/17/25 at 5:40pm revealed:</p> <ul style="list-style-type: none"> <li>-She was not aware that the MAs were not</li> </ul>	D 273		

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D 273	<p>Continued From page 2</p> <p>always notifying or documenting that they notified Resident #2's PCP when her systolic blood pressure and/or pulse was outside of ordered parameters. -Her expectation was that the MAs would follow PCP orders.</p> <p>Interview with the Administrator on 09/17/25 at 6pm revealed: -She believed the HWD did audits on eMARs every day to make sure documentation was complete. -She was not aware that when Resident #2's systolic blood pressure and/or pulse was outside of the PCP ordered parameters, the PCP was not notified or that it was not documented that the PCP was notified. -Her expectation was that the PCP would be notified whenever Resident #2's systolic blood pressure and/or pulse was outside of parameters. -She would request that the Regional Nurse provide additional eMAR training for all the MAs.</p> <p>Telephone interview with Resident #2's PCP on 09/17/25 at 4:50pm was unsuccessful.</p>	D 273		
{D 358}	<p>10A NCAC 13F .1004 (a) Medication Administration</p> <p>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.</p>	{D 358}		

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{D 358}	<p>Continued From page 3</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were administered as prescribed for 2 of 5 sampled residents (Resident #1) related to medications used to control elevated blood sugar, a screening to control glucose levels, and (Resident #3) related to medications used to treat high blood pressure.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 05/21/25 revealed: -Diagnoses included Type 2 diabetes, acute kidney injury, hypertension and heart disease.</p> <p>Review of Resident #1's signed Physician orders dated 07/09/25 revealed: -There was an order to monitor finger stick blood sugar (FSBS) before each meal and at bedtime, four times a day for blood sugar control and call if FSBS was less than 80 or greater than 400. -There was an order for Humalog KwikPen (a quick acting insulin to lower blood sugars), 100 units, inject 3 units subcutaneously with meals for blood glucose control and give with sliding scale insulin. -There was an order for Insulin Glargine (a long acting insulin to lower blood sugars) 100 units inject 13 units subcutaneously at bedtime for diabetes.</p> <p>Review of Resident #1's August 2025 Medication Administration Record (eMAR) revealed: -There was an entry to monitor FSBS before each meal and at bedtime, four times a day for blood sugar control. -There was no documentation on 08/22/25 at 8:00pm and 08/29/25 at 12:00pm to show the</p>	{D 358}		

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{D 358}	<p>Continued From page 4</p> <p>FSBS was monitored for blood sugar control.</p> <ul style="list-style-type: none"> <li>-There was an entry for Humalog Kwik-Pen 100 units give 3 units subcutaneously with meals for blood glucose control.</li> <li>-There was no documentation on 08/29/25 at 12:00pm to show Humalog Kwik-Pen 100 units was given for blood glucose control.</li> <li>-There was an entry for Insulin Glargine 100 units inject 13 units subcutaneously at bedtime for diabetes.</li> <li>-There was no documentation on 08/22/25 at 8:00pm to show Insulin Glargine 100 units were given at bedtime for diabetes.</li> </ul> <p>Observation of medications on hand for Resident #1 on 09/17/25 revealed:</p> <ul style="list-style-type: none"> <li>-Humalog Kwik-Pen 100 units dated 09/11/25, one pen.</li> <li>-Insulin Glargine 100 units dated 09/14/25, two pens.</li> <li>-Humalog Kwik-Pen 100 units give per sliding scale, dated 09/14/25, two pens.</li> </ul> <p>Attempted telephone interview with a representative from the facility's contracted pharmacy on 09/17/25 at 4:35pm was unsuccessful.</p> <p>Attempted telephone interview with Resident #1's Primary Care Physician (PCP) on 09/17/25 at 4:10pm was unsuccessful.</p> <p>Interview with the Medication Aide (MA) on 09/17/25 at 5:00pm revealed:</p> <ul style="list-style-type: none"> <li>-She did not know there was areas on the eMAR without documentation.</li> <li>-Third shift completed cart audits but did not know if audits were completed on eMAR to the chart audits.</li> <li>-Resident #1 does not use our facility pharmacy</li> </ul>	{D 358}		

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{D 358}	<p>Continued From page 5</p> <p>or PCP and we struggled with getting any response from them.</p> <p>Interview with the Health and Wellness Director (HWD) on 09/17/25 at 5:27pm revealed:</p> <ul style="list-style-type: none"> <li>-She was not aware Resident #1 had missed documentation on the eMARs.</li> <li>-We had inservices recently for staff regarding medication administration and charting.</li> <li>-She expected them to chart each medication or FSBS.</li> <li>-The third shift completed cart audits weekly and the HWD would do cart audits and spot checks on the carts.</li> <li>-She thought the MAs were documenting when they dispensed medication but there was a documentation button that was displayed and she would have to check to see if it was working.</li> </ul> <p>Interview with the Administrator on 09/17/25 at 5:59pm revealed:</p> <ul style="list-style-type: none"> <li>-She was not aware Resident #1 had missed documentation on the eMARs.</li> <li>-She expected for staff to document after giving each medication or when completing a FSBS.</li> <li>-She was aware the third shift staff did cart audits weekly but was not sure why a cart to eMAR audit was not completed.</li> <li>-Her expectation was for all medications and FSBS's to be documented.</li> </ul> <p>2. Review of Resident #3's current FL2 dated 08/07/25 revealed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included congestive heart failure, hypertension, and cellulitis of limb.</li> <li>-Resident #3 was ambulatory.</li> <li>-Resident #3 was oriented.</li> </ul> <p>Review of Resident #3's Resident Register</p>	{D 358}		

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{D 358}	<p>Continued From page 6</p> <p>revealed an admission date of 08/11/24.</p> <p>Review of Resident #3's signed physician orders dated 09/01/25 revealed there was an order to hold valsartan (a medication to lower blood pressure) 80mg if systolic blood pressure (SBP) was less than 120 and diastolic blood pressure (DBP) was less than 80.</p> <p>Review of Resident #3's August 2025 Medication Administration Record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for valsartan 80mg, 1 tablet by mouth twice daily, for blood pressure (BP), check blood pressure before administering medication, hold medication for systolic blood pressure (SBP) less than 120 and/or diastolic blood pressure (DBP) less than 80, hold for heart rate less than 60.</li> <li>-There was documentation dated 08/03/25 (7:00am) Resident #3 was administered valsartan 80mg and her BP of 141/78 was outside of the parameters.</li> <li>-There was documentation dated 08/13/25 (7:00pm) Resident #3's valsartan 80mg was held and no BP reading was entered.</li> <li>-There was documentation dated 08/17/25 (7:00pm) Resident #3's valsartan 80mg was held and no BP was entered.</li> <li>-There was documentation dated 08/19/25 (7:00am) Resident #3 was administered valsartan 80mg and her BP reading of 168/75 was outside of the parameters.</li> <li>- There was documentation dated 08/20/25 (7:00am) Resident #3 was administered valsartan 80mg and her BP reading of 149/75 was outside of the parameters.</li> <li>-There was documentation dated 08/20/25 (7:00pm) Resident #3's valsartan 80mg was held and no BP reading was entered.</li> <li>- There was documentation dated 08/27/25</li> </ul>	{D 358}		

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{D 358}	<p>Continued From page 7</p> <p>(7:00am) Resident #3 was administered valsartan 80mg and her BP reading of 121/71 was outside of the parameters.</p> <p>Review of Resident #3's September 2025 Medication Administration Record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for valsartan 80mg, 1 tab by mouth twice daily, for blood pressure, check BP before administering medication, hold medication for systolic blood pressure (SBP) less than 120 and/or diastolic blood pressure (DBP) less than 80, hold for heart rate less than 60.</li> <li>-There was documentation dated 09/14/25 (7:00am) Resident #3 was administered valsartan 80mg and her BP reading of 127/77 was outside of the parameters.</li> <li>-There was documentation dated 09/15/25 (7:00pm) Resident #3 was administered valsartan 80mg and her BP reading of 168/75 was outside of the parameters.</li> </ul> <p>Interview with the Health and Wellness Director (HWD) on 09/17/25 at 5:27pm revealed:</p> <ul style="list-style-type: none"> <li>-She was made aware on 09/17/25 Resident #3 was administered valsartan 80mg on four occasions in August 2025 although blood pressure readings were outside of the physician ordered parameters.</li> <li>-She did not know there were three other occasions in August 2025 where Resident #3's valsartan 80mg was held and no BP readings were entered.</li> <li>-MAs were recently in-serviced regarding medication administration, notifying the physician, parameters and charting.</li> <li>-Although the HWD and MAs performed weekly medication cart audits, BP parameters were not audited regularly to ensure medication was being held as ordered.</li> </ul>	{D 358}		

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{D 358}	<p>Continued From page 8</p> <p>-She expected MAs to hold medications according to the physician's order and document appropriately.</p> <p>-She expected MAs to compare and follow the directions on eMAR order before administering each medication.</p> <p>Interview with the Administrator on 09/17/25 at 5:59pm revealed:</p> <p>-She was not aware Resident #3 was administered valsartan 80mg although her BP was outside the parameters.</p> <p>-The HWD and designees were responsible for performing spot check medication audits in addition to weekly cart audits.</p> <p>-She expected MAs to compare and follow the directions on eMAR order before administering each medication.</p> <p>Attempted telephone interview with the MA on 09/17/25 at 4:35pm was unsuccessful.</p>	{D 358}		
D 451	<p>10A NCAC 13F .1212(a) Reporting of Accidents and Incidents</p> <p>10A NCAC 13F .1212 Reporting of Accidents and Incidents</p> <p>(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.</p> <p>This Rule is not met as evidenced by:</p>	D 451		

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D 451	<p>Continued From page 9</p> <p>Based on record reviews and interviews, the facility failed to notify the county Department of Social Services (DSS) for incidents involving 2 of 5 sampled residents (Resident #3 and #4) who received injuries that required emergency medical treatment.</p> <p>Review of facility's incident report policy dated October 2022 revealed:</p> <ul style="list-style-type: none"> <li>-An incident report must be completed when a resident or visitor experiences an occurrence that is unusual, improper, or harmful.</li> <li>-Incidents may include, but are not limited to, injuries, falls, theft, unexplained absences, sudden illness, and combative behavior.</li> <li>- The resident's physician, family, and responsible person and sponsoring agency, if applicable, should be notified.</li> <li>-The incident report must be completed with all the requested information.</li> <li>- A healthcare related incident is reviewed by the nurse or designee. Corrective actions or suggestions will be made and submitted to the Executive Director.</li> <li>-The Executive Director or designee will notify the Regional Director of Operations of any serious incidents according to the Reportable Events Policy &amp; Procedure and enter the incident into the incident report system.</li> <li>- Incidents or accidents resulting in death or requiring referral for emergency medical evaluation, hospitalization or medical treatment other than first aid shall be reported to the DSS.</li> <li>-The completed report should be printed and submitted to the county DSS by mail, fax, electronic mail, or in person within 48 hours of the initial discovery or knowledge by associates of the accident or incident.</li> <li>-The Eecutive Director will investigate and evaluate the incident and document any</li> </ul>	D 451		

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D 451	<p>Continued From page 10</p> <p>appropriate corrective and preventative actions.</p> <p>1. Review of Resident #3's current FL2 dated 08/07/25 revealed: -Diagnoses included congestive heart failure and hypertension (high blood pressure). -She was not disoriented. -She was ambulatory.</p> <p>Review of Resident #3's record revealed: - She went out with family on 08/31/25. -Upon return the family member notified staff Resident #3 had a fall while they were out. - Resident #3 stated she did not hit her head. - Staff requested the family member take Resident #3 to the hospital for evaluation because she was on a blood thinner.</p> <p>Review of incident log dated 08/31/25 at 7:00pm revealed: -Resident #3 was out with family. -Resident #3 fell while with family. - Resident #3's power of attorney (POA)was to take Resident #3 to be evaluated. -No injuries were noted by hospital. -There was no incident report completed on 08/31/25.</p> <p>Review of Resident #3's 08/31/25 emergency room visit discharge summary revealed: -The reason for the visit was fall. -Diagnoses were head injury and fall. -Resident #3's blood pressure was 93/46, pulse was 53, and oxygen saturation was 92%. -Lab test and images were completed.</p> <p>Refer to interview with the Health and Wellness Director (HWD) on 09/17/25 at 6:00pm.</p> <p>Refer to interview with the Administrator on</p>	D 451		

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(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 451	<p>Continued From page 11</p> <p>09/17/25 at 6:05pm.</p> <p>2.Review of Resident #4's current FL2 dated 06/30/25 revealed: -Diagnoses included weakness, chronic respiratory failure with hypoxia with oxygen, and light headedness.</p> <p>Review of Resident #4's nurses' notes dated 09/11/25 revealed: - Resident #4 had 3 falls on 09/11/25 about 30 minutes apart. -Resident #4 was sent to the emergency room (ER) after the 3rd fall. -Resident #4's family and doctor were notified. -The facility did not have documentation from the ER because Resident #4 went to a rehabilitation facility at hospital discharge. -There was no incident report completed on 09/11/25.</p> <p>Refer to interview with the Health and Wellness Director (HWD) on 09/17/25 at 6:00pm. Refer to interview with the Administrator on 09/17/25 at 6:05pm.</p> <p>_____</p> <p>Interview with the Health and Wellness Director (HWD) on 09/17/25 at 6:00pm revealed: -Incident reports were completed by herself or the Resident Care Director (RCD). -If the HWD or RCD were not available the incident report was completed by the medication aide (MA). -The MA's were aware to send accident and incident reports to the county DSS when residents hit their head but were unsure about other accidents and incidents.</p>	D 451		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL036015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/17/2025</b>
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D 451	<p>Continued From page 12</p> <p>Interview with the Administrator on 09/17/25 at 6:05pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff reported to her Resident #4 fell three (3) times within 30 minutes of each fall, trying to pick up a pen off the floor.</li> <li>-The incidents were documented on the incident log, but not sent to the county DSS.</li> <li>-She and the HWD were responsible to complete the incident reports.</li> <li>-If the Administrator or HWD were not in the facility at the time of the incident they would return to the facility to complete the incident report and fax to the county DSS.</li> </ul>	D 451		