

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/07/2025
NAME OF PROVIDER OR SUPPLIER  Brookdale Carriage Club Providence		STREET ADDRESS, CITY, STATE, ZIP CODE  5804 Old Providence Road Charlotte, NC 28226	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and staff interviews, the facility failed to treat 1 of 3 sampled residents with dignity by performing care in a manner that the resident felt was rude and hurried (Resident #117).</p> <p>The findings included:</p> <p>Resident #117 admitted to the facility on [DATE] with diagnoses which included a compression fracture of the second lumbar vertebra.</p> <p>A review of Resident #117's comprehensive care plan dated [DATE] revealed a focus area for alteration in musculoskeletal status related to the compression fracture of the second lumbar vertebra. The interventions included that she required the mechanical lift for transfers.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #117 was cognitively intact.</p> <p>An initial allegation report dated [DATE] revealed an allegation of abuse. The allegation indicated on [DATE] Resident #117 called the Administrator to her room to express concerns about NA #1 when she was providing her care the evening of [DATE]. Resident #117 told the Administrator that NA #1 was getting her into bed for the night and turned her on her side and her legs hit one another and she yelled out oh, that hurts. NA #1 stated I need to get these off referring to her shoes and socks. Resident #117 stated she proceeded in a rude and hurried fashion. Resident #117 requested NA #1 not come back to her room in the future. The initial allegation report was signed by the Administrator.</p> <p>A telephone interview on [DATE] at 12:58 PM with NA #1 revealed that she (NA #1) did not recall Resident #117. She further revealed she had never had any issues with any residents during a mechanical lift transfer.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview on [DATE] at 11:19 AM with NA #2 revealed on [DATE] she was assisting with Resident #117's transfer back to bed when NA #1 moved the mechanical lift in a jerky, rushed manner which caused the mechanical lift to swing and resulted in Resident #117 yelling out in pain. NA #2 stated she intervened and told NA #1 to slow down and be more careful. NA #2 indicated she moved to the other side of the bed to guide Resident #117 in the mechanical lift and ease her down onto the bed. Resident #117 asked for pain medication. Once secure in bed, she (NA #2) left the room to find Nurse #1 to advise that Resident #117 was asking for pain medication and to also report NA #1 as NA #2 thought her behavior was unsafe and not caring toward Resident #117. NA #2 also reported the incident to the Administrator the morning of [DATE]. NA #2 stated she cared for Resident #117 after the incident and never saw any new bruising or visible injuries. NA #2 stated Resident #117 was alert and oriented, could direct her own care and never displayed any behavior issues. NA #2 stated she had left the room to locate Nurse #1 and did not witness NA #1 taking off Resident #117's pants without removing her shoes first.</p> <p>A telephone interview on [DATE] at 11:49 AM with Nurse #1 revealed that she was giving report on [DATE] to the next shift nurse when NA #2 advised her Resident #117 requested pain medication and reported NA #1 had been rude to Resident #117, used the mechanical lift in a hurried fashion and had not shown concern when Resident #117 had expressed pain. Nurse #1 stated NA #2 told her NA #1 had not treated Resident #117 properly or in a caring manner. Nurse #1 stated she reported the incident to the Administrator on [DATE].</p> <p>A social services progress note dated [DATE] indicated Resident #117 was in a pleasant mood, reported progress in her physical therapy and expressed no concerns.</p> <p>The investigation report dated [DATE] revealed additional details that included NA #1 was very rushed in her care of Resident #117 on [DATE] and attempted to remove Resident #117's pants without removing her shoes first. NA #1 had been using the mechanical lift to transfer Resident #117 into bed and NA #2 witnessed NA #1 rushing through the transfer process causing the mechanical lift to swing. NA #1 was suspended on [DATE] and employment subsequently terminated for lack of customer service and care. The investigation report was signed by the Administrator.</p> <p>A nursing progress note dated [DATE] at 4:28 PM stated Resident #117 was pronounced deceased by Hospice at 4:06 PM.</p> <p>An interview on [DATE] at 2:37 PM with the Administrator revealed she was called to Resident #117's room the morning of [DATE]. Resident #117 reported that NA #1 had been rude and hurried when getting her back into bed using the mechanical lift and when taking off her pants without removing her shoes first. The Administrator stated after the facility's investigation, the resident's abuse allegation was not substantiated. NA #1 was terminated due to poor customer service and care.</p>