STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0574	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CARRIAGE CLUB PROVIDENCE	5804 OLD PROVIDENCE ROAD CHARLOTTE, NC 28226

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L 000	INITIAL COMMENTS An unannounced onsite complaint investigation survey was conducted on 5/14/25-5/16/25. The following intakes were investigated NC00230110 and NC00229879. Event ID #SSO911. 1 of the 2 allegations resulted in a deficiency.	L 000		
L 091	.2306(D)(1) MEDICATION ADMINISTRATION 10A-13D.2306 (d) The facility shall ensure that procedures aimed at minimizing medication error rates include the following: (1) All medications or drugs and treatments shall be administered and discontinued in accordance with signed medical orders which are recorded in the patient's medical record. Such orders shall be complete and include drug name, strength, quantity to be administered, route of administration, frequency and, if ordered on an as-needed basis, a stated indication for use. This Rule is not met as evidenced by: Based on record reviews, and Responsible Party, Attending Physician, Nurse Practitioner (NP), and staff interviews, the facility failed to administer a physician's order for Vancomycin HCL (an intravenous antibiotic solution) for suspected osteomyelitis (an inflammation and infection of the bone) and failed to notify the medical provider for 1 of 3 residents reviewed for medication errors (Resident #1). The findings included: Resident #1 was admitted to the facility on 4/21/25 with diagnoses which included sepsis, acute transverse myelitis, and paraplegia.	L 091	L091 .2306(D)(1) Medication Administration I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies.	5/23/25

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L 091	Continued From page 1 The admission Minimum Data Set (MDS) assessment dated 4/27/25 indicated Resident #1 was cognitively intact and required moderate to extensive assistance from staff with activities of daily living (ADL). The admission MDS also indicated Resident #1 was admitted to the facility with three unstageable pressure ulcers, two of which were classified as deep tissue injuries. A review of Resident #1's wound care progress note on 4/28/25 revealed the Wound Care Physician evaluated Resident #1's wounds and ordered treatment plans. She collected a tissue sample from Resident #1's sacral wound to culture. A review of Resident #1's wound culture results on 5/1/25 revealed the sacral wound infection was sensitive to several antibiotics, including Vancomycin. A review of Resident #1's physician orders revealed an order acknowledged by Nurse #1 dated 5/2/25 for Vancomycin HCl intravenous solution to be given every 12 hours for suspected osteomyelitis. A review of Resident #1's Medication Administration Record (MAR) indicated contacting an intravenous (IV) team for placement of a peripherally inserted central catheter (PICC) line (a thin, flexible tube inserted into a vein in the arm and advanced into a larger vein in the chest) for Vancomycin treatment for osteomyelitis on 5/3/25. The task was not signed off by any clinical staff on 5/3/25. A review of the facility's initial allegation report dated 5/5/25 and signed by the Executive Director	L 091	How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On, 5/5/25, resident #1 was seen by the Nurse Practitioner. The Licensed nurse obtained an order to send resident # 1 to the hospital due to increased white blood cell count, sacral wound, confusion, and hypotension. Resident # 1 was admitted to the hospital. On 5/9/2025, impromptu Quality Assurance Performance Improvement Meeting was completed with the Assistant Director of Clinical Services, Healthcare Administrator, and Medical Director to discuss root cause analysis How will the facility identify other residents having the potential to be affected by the same deficient practice? On, 5/5/25, a licensed nurse completed an audit of current resident medication orders to determine if there was any additional orders for intravenous (IV) medications. No additional residents identified with IV medication orders. On 5/5/25, a licensed nurse completed an expanded audit of other medications for current residents for omissions of medications from 5/2/25- 5/5/25. On 5/6/25, the Assistant Director of Clinical Services (ADCS) audited the community's IV emergency kit inventory to verify that IV Vancomycin and IV Start Kits	

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L 091	Continued From page 2 revealed Resident #1 had an order for an IV antibiotic received on 5/2/25 which had been acknowledged by clinical staff but had not been administered to Resident #1 as of 5/5/25. Resident #1 was sent to the hospital on 5/5/25 due to confusion, lethargy, and hypotension. A telephone interview with Nurse #1 on 5/15/25 at 10:21 AM revealed she worked at the facility on 5/2/25 but was not assigned to Resident #1. She stated when she started her shift, she noticed one of her residents had an antibiotic order that was not processed earlier in the day by Nurse #2. Nurse #1 stated none of the orders from first shift on 5/2/25 had been processed by Nurse #2. She stated she went ahead and processed the antibiotic order for Resident #1. Nurse #1 stated typically when the medical provider writes an order on a shift, the nurse working that shift was required to process the order by putting it in the system and alerting the pharmacy. She stated Nurse #3 was able to get an order on 5/3/25 for the IV team to come and place a PICC line for Resident #1. Multiple attempts were made to contact Nurse #2 and were unsuccessful. A telephone interview with Nurse #3 on 5/14/25 at 1:27 PM revealed she worked at the facility on 5/3/25 and 5/4/25 and contacted the medical provider care portal to get an order to place a PICC line for Resident #1 on 5/3/25. She stated after receiving the order, she called the company that supplied the IV placement team. Nurse #3 stated the account information needed for the company was stored in a binder normally at the nurse's desk, but that day the binder was missing. She stated she and other nursing staff looked everywhere for the binder and alerted their	L 091	were available. Items were identified as available in the IV emergency kit. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? On 5/5/2025, Healthcare Administrator (HCA) provided the licensed nurses with a written copy of the on call contact names and numbers for Assistant Director of Clinical Services, Healthcare Administrator and Executive Director. On 5/6/5, the HCA provided the licensed nurses with the updated third party IV Services Flyer. On 5/7/25, the HCA ordered a Venipuncture Training Aid to assist with ongoing training and competencies for licensed nurse. The Venipuncture Training Aid was delivered on 5/14/25. On 5/6/25, The Regional Director of Clinical Services (RDCS) re-educated the ADCS on the following items. • 24 hour chart check process including review of order listing report. • Ordering IV meds from the pharmacy. • Follow up with the pharmacy for medications not available. • Notifying of Healthcare Provider if a medication is not available. • Use of emergency kit and removal of medications. • Reviewing the electronic medical record dashboard on medication that hasn’t been administered • Reviewing med pass during shift changes-licensed nurse to notify	

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L 091	Continued From page 3 Assistant Director of Nursing (ADON) and Administrator but did not receive a return call. She indicated the binder was found later in the downstairs conference room by management. Nurse #3 stated she did not think of sending Resident #1 to the hospital or alerting the medical provider. A telephone interview with the Attending Physician on 5/14/25 at 3:21 PM revealed the Wound Care Physician evaluated Resident #1's wounds on 4/28/25 and collected a tissue sample for a culture. The Attending Physician stated she had not seen Resident #1's wound but when the results from the wound culture came back, she spoke to Resident #1's Responsible Party and they decided to treat the suspected osteomyelitis with a course of IV antibiotics. She wrote the order for the Vancomycin on 5/2/25. The Attending Physician stated she expected the nursing staff to process an order for an IV line if there was a physician's order for an IV medication. Multiple attempts were made to contact the Wound Care Physician but were unsuccessful. A telephone interview with the NP on 5/14/25 at 4:25 PM revealed she evaluated Resident #1 on 5/1/25 and stated she was at her baseline, alert with no fever. She stated the Vancomycin was ordered by the Attending Physician on 5/2/25. The NP stated she visited Resident #1 on 5/5/25 as a follow up to her 5/1/25 visit and found her confused and somnolent with low blood pressure. The NP stated her expectation was if an IV medication was ordered, then nursing staff should have processed an order for an IV or PICC line the same day the medication was ordered.	L 091	supervisor if meds not signed off. • Abuse/Neglect/Misappropriation • Third Party IV Services • Attempting peripheral IV per licensed nurse scope of practice and contacting third party IV Services as needed. On 5/7/25, the RDCS and ADCS re-educated licensed nurses on the following items. • 24 hour chart check process including review of order listing report. • Ordering IV meds from the pharmacy. • Follow up with the pharmacy for medications not available. • Notifying of Healthcare Provider if a medication is not available. • Use of emergency kit and removal of medications. • Reviewing the electronic medical record dashboard on medication that hasn't been administered • Reviewing med pass during shift changes-licensed nurse to notify supervisor if meds not signed off. • Abuse/Neglect/Misappropriation • Third Party IV Services • Attempting peripheral IV per licensed nurse scope of practice and contacting third party IV Services as needed. Licensed Nurses not available during initial training will be re-educated prior to their next scheduled shift by the ADCS and/ or designee. This would include new hires. On 5/22/25, a third party vendor completed IV classes for licensed nurses. On 5/9/25, Healthcare Administrator re-trained all managers who cover the weekend manager on duty on inquiring	

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L 091	Continued From page 4 A second interview with the NP occurred on 5/15/25 at 12:12 PM. She stated when she visited Resident #1 on 5/5/25, she found out the Vancomycin had not been given and no one from the nursing staff alerted her from 5/2/25 to 5/5/25 that the medication had not been given. The NP stated the facility did not do very many IV treatments, but they have been done before. She stated any nurse on duty could have started an IV to complete the Vancomycin treatment and the IV team did not have to be brought in from the outside for a PICC line. The NP stated she was not sure when Resident #1's status changed but she was more confused on 5/5/25 than when she evaluated her on 5/1/25. A telephone interview with the ADON on 5/15/25 at 2:41 PM revealed an order for Vancomycin to be given intravenously was written on 5/2/25 for Resident #1 and the order was not processed during first shift. She stated Nurse #3 attempted to get a PICC line placed by attempting to call the IV team. The ADON stated there was an issue with locating a binder with the correct account information for the outside IV team, and Nurse #3 could not locate the information on 5/3/25 or 5/4/25. The ADON stated when she came in on 5/5/25, she realized no IV or PICC line was placed, and the NP wrote an order to have Resident #1 sent to the hospital. She stated the binder with the IV team information and account number was later found in the conference room. The ADON explained any nurse could have started an IV for the Vancomycin, but the protocol the staff typically followed was to have a PICC line for any IV meds in the facility. She stated the facility does not typically have a lot of IV medications, but any nurse could have started an IV.	L 091	about medications that are not available from pharmacy. Managers are instructed to call Nurse Leader/ Healthcare Administrator as needed. The Director of Clinical Services/ Assistant Director of Clinical Services and/ or designee will review the order listing report and missed medications in stand up meeting and report follow up in stand down meeting daily (Monday- Friday) Manager on Duty and/ or designee will check with licensed nurses during rounding on the weekends to verify that that medications are available or provide direction for on call support. How will the facility monitor its' performance to make sure that solutions are sustained? The Director of Clinical Services and/ or designee will review audits 3 residents a week to verify that medications were given per Healthcare Provider Orders weekly for 3 month. The Director of Clinical Services and/ or designee will review the results of the audit monthly at the Quality Assurance Performance Improvement meeting for three months. Compliance Date: 5/23/25	

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L 091	Continued From page 5 A telephone interview with Resident #1's Responsible Party on 5/15/25 at 3:14 PM revealed Resident #1 came to the facility with multiple pressure ulcers from the hospital. She stated she discussed the treatment plan for Resident #1's sacral wound with the Medical Director on 5/2/25 and wanted to go ahead and treat the potential infection with IV antibiotics. She stated Resident #1 never received the IV medication and was sent to the hospital on 5/5/25. She stated she was arriving for a care plan meeting with the interdisciplinary team on 5/5/25 when Resident #1 was being sent out by ambulance. A telephone interview with the Administrator on 5/16/25 at 2:10 PM revealed she had the expectation that the nursing staff should have given Resident #1 the ordered IV antibiotic as written. She stated the facility initiated education for staff immediately to include an IV training class on 5/22/25. The facility presented a plan of correction that was not accepted by the State Survey Agency. The facility indicated they started an immediate education plan with nursing staff after Resident #1 was sent to the hospital. According to the Administrator's interview on 5/16/25 at 2:10 PM and the Administrator's statement in the Investigation Report sent to the State Survey Agency on 5/9/25, the nursing staff would receive training on IV insertion on 5/22/25.	L 091		