STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060060	A. BUILDING: _____ B. WING _____	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHARLOTTE EAST	6053 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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 conducted an annual and follow-up survey on July 17-July 18, 2024.	D 000	Orders will be signed by Clinical staff (medication aid, nurse, RCC, HWD), once processed and placed in the new orders box, located in Med Room. The RCC and HWD will remove the orders from the box and confirm that they were entered and processed correctly on a daily basis Medication Admin Records will be reviewed on a daily basis for 4 weeks then it will occur weekly thereafter Med Aids will receive re-training on the new order process w/focus on delay vital sign + documentation by Aug 23, 2024. Any Communication regarding prescribed monitoring of resident vital signs + subsequent reads will be documented in the resident record.	
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement physician's orders for 1 of 2 sampled residents for blood pressure checks daily for seven days (Resident #4). The findings are: Review of Resident #4's current FL2 dated 10/13/23 revealed diagnoses included cardiac pacemaker, atrial fibrillation and hypertension. Review of Resident #4's physician order dated 05/03/24 revealed there was an order to monitor blood pressure every morning for seven days and to notify the Primary Care Provider (PCP) for blood pressures less than 100/60. Review of Resident #4's May 2024 electronic Medication Administration Record (eMAR) revealed there was no entry for blood pressure checks every morning for seven days.	D 276		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Abby S Pleasant TITLE Executive Director (X6) DATE 8/5/24

Reviewed & acknowledged on 08/06/2024 Susan Spector RN

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D 276	Continued From page 1 Interview with Resident #4's PCP on 07/18/24 at 11:33am revealed: -She had ordered blood pressure checks on 05/03/24 for seven days for Resident #4 due to concern for hypotension (low blood pressure that causes dizziness due to the brain not receiving enough blood) and possible cancer. -She did not go back and check to see if Resident #4 had received daily blood pressures because the resident had been seen by Oncology services shortly after she had ordered the blood pressure checks. -She expected the facility to ensure all physician orders were implemented. Interview with the Health and Wellness Director (HWD) on 07/18/24 at 1:30pm revealed: -She did not know Resident #4 had an order on 05/03/24 for blood pressure checks every morning for seven days. -It was the responsibility of the HWD, the Resident Care Coordinator (RCC), medication aides (MA) and the licensed practical nurses (LPN) to ensure orders for blood pressure checks were entered into the eMAR system. -Resident #4's order for blood pressure checks had been missed. Interview with the Administrator on 07/18/24 at 1:30pm revealed: -She did not know Resident #4 had an order on 05/03/24 for blood pressure checks every morning for seven days. -The HWD, RCC, MAs and LPNs were responsible for entering orders into the eMAR system.	D 276		