STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345482	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Carriage Club Providence	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51936 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). The findings included: Resident #117 admitted to the facility on [DATE] with diagnoses which included a compression fracture of the second lumbar vertebra. 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. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #117 was cognitively intact. 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. 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. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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]. 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. 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. A nursing progress note dated [DATE] at 4:28 PM stated Resident #117 was pronounced deceased by Hospice at 4:06 PM. 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.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51936 Based on record review, and staff and nurse practitioner interviews, the facility failed to maintain accurate advance directive information throughout the electronic and paper medical records for 1 of 3 residents reviewed for advance directive (Resident #119). The findings included: Resident #119 was admitted to the facility on [DATE]. A review of the nursing admission note dated [DATE] at 2:42 PM indicated that Resident #119 was alert and verbal. A review of Resident #119's electronic medical record revealed an order written by the nurse practitioner dated [DATE] for full code status. This order was created by the Director of Clinical Services. A review of Resident #119's comprehensive care plan revealed a focus area for advance directives initiated on [DATE] indicating Resident #119's code status was a full code. The goal was for Resident #119's wishes and directives to be carried out in accordance with her advanced directives through the next review date. An intervention was to honor resident choice for code status. A review of the paper medical record revealed on [DATE] Resident #119 signed a Medical Orders for Scope of Treatment (MOST) form for do not attempt resuscitation (DNR/no cardiopulmonary resuscitation (CPR). Further review of the paper medical record revealed a Golden Rod DNR form signed on [DATE] by the Nurse Practitioner. Resident #119's admission Minimum Data Set (MDS) dated [DATE] revealed that it was in progress. An interview on [DATE] at 10:19 AM with the Nurse Practitioner (NP) revealed she met with Resident #119 on [DATE] and confirmed Resident #119's advance directive choice which was a DNR status. The NP stated the order for a full code was not correct and should have been updated when the MOST form and Golden Rod form were completed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on [DATE] at 11:30 AM with the Director of Clinical Services revealed she recalled there was confusion regarding what Resident #119's advance directive wishes were on admission. She stated she discussed advance directive choice with Resident #119 on admission. She was not clear what Resident #119 wanted after the discussion. As a result of this confusion, the Nurse Practitioner and the Director of Clinical Services made Resident #119 a full code status until the Nurse Practitioner could discuss advance directives further with Resident #119. The Director of Clinical Services reported if Resident #119 had experienced an emergency, the nurse would have followed the information in the electronic medical record which showed full code status. The Director of Clinical Services stated that both the electronic medical record and paper medical record should always reflect the same information regarding advance directives. She stated the Nurse Practitioner order should have been updated after Resident #119 signed the MOST form dated [DATE]. She indicated she was responsible for the care plan and should have updated it to reflect Resident #119's DNR status as of [DATE]. An interview on [DATE] at 2:19 PM with the Administrator indicated Resident #119's advance directive information was not correct across the electronic medical record and the paper medical record. She stated that advance directive information was very important and should always be accurate and up to date to reflect the resident's choice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51838 Based on observation and staff interviews, the facility failed to perform hand hygiene between handling soiled and then clean dishes to prevent cross-contamination of the clean dishes. These practices had the potential to affect food served and distributed to 9 of 9 residents who received an oral diet. Findings included: A continuous observation of the skilled nursing satellite kitchen was conducted on 04/02/25 from 1:09 PM through 1:16 PM. Dietary Aide #1 was observed operating the dish machine and washing dishes. Dietary Aide #1 had gloves on both hands with left hand glove observed with large ripped in area over the palm. While waiting for the dish cycle to complete, she removed food debris from soiled plates in the sink area located to the right of the dish machine in the dish room and then moved to the drying area side of the dish machine wearing the same gloves. Dietary Aide #1 then opened the dish machine after the washing cycle was completed. She removed all the clean dishes which consisted of 8 bowls, 2 plates, 1 soup bowl, 4 ice cream scoops, 5 pieces of silverware, and 3 metal food storage bins out of the dish machine without removing her gloves or washing her hands and placed these items on a drying rack in the drying area. During the observation, the Kitchen Supervisor stepped into the dishwashing area and asked Dietary Aide #1 for a pair of tongs. Dietary Aide #1 was observed reaching for the tongs on the wall holder with the same torn gloved hand. Dietary Aide #1 touched the tooth area of the tongs but could not get the tongs off the wall holder. The Corporate Kitchen Supervisor then entered the dishwashing area and grabbed the tongs down from the drying area and exited the dishwashing area with the tongs. An interview with Dietary Aide #1 was conducted 04/02/25 at 1:16 PM who stated she was behind in food service today and that was why she had not changed her gloves or washed her hands between touching soiled plates and then clean dishware. She indicated that she usually wears 3 pairs of gloves to remove a pair when contaminated between the dirty and clean dishes. Dietary Aide #1 had been trained on the dish machine when she was hired. She verbalized she was aware that she should have washed her hands and changed her gloves before going from dirty to clean dishes, and if gloves were soiled or torn. She explained what occurred today had been due to being behind on service. An interview with the Dietitian and Corporate Kitchen Supervisor on 04/02/25 at 1:24 PM revealed staff performing dishwashing would not handle dirty dishes and then touch clean dishes without removing gloves and washing their hands in between. The Dietitian stated that multiple gloves should not be used and if a glove was torn, it should be changed immediately. An interview with the Administrator on 04/02/25 at 03:43 PM revealed that she was not familiar with the specific dishwashing procedure the facility follows.