STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 and the Mecklenburg County Department of Social Services conducted an annual survey and complaint investigation on February 18-20, 2020. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on February 13, 2020.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up for 2 of 7 sampled residents regarding notifying the physician for drainage from the insertion site of a suprapubic catheter (Resident #1) and regarding a delayed referral for a mental health consultation (Resident #3). The findings are: 1. Review of Resident #3's current FL2 dated 02/04/20 revealed diagnoses included hypertension, cerebral infarction, and cognitive	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 1 communication deficit. Review of Resident #3's Resident Register revealed he was admitted on 07/30/19. Review of a psychotherapy progress note dated 01/08/20 revealed Resident #3's diagnoses included unspecified mood disorder, unspecified dementia with behavioral disturbance, and paranoid schizophrenia. Review of Resident #3's progress notes revealed: -There was a note dated 07/31/19 at 10:57pm documenting the resident had an altercation with another resident that led to being physical. -There was a note dated 08/02/19 at 2:40pm documenting the resident was combative towards roommate, he was moved to [room number]. -There was a note dated 08/06/19 at 10:17pm and 10:25pm documenting the resident became upset because he did not want to wait for the medication aide to administer his medication, he was asked to wait as the medication aide was passing out medications to another resident, the resident stood up out of his wheelchair and threatened to slap the medication aide in the face. -There was a note dated 08/18/19 at 9:41am documenting the "resident was combative towards roommate, the med tech and manager on duty stepped in, the executive director instructed staff to send resident to psych [sic] for an evaluation, he was transported to the hospital". -There was a note dated 08/29/19 at 7:11pm documenting the resident provoked a physical altercation in the hallway with another resident, the resident was stopped in the middle of the hallway hitting and cursing the other resident in the face.	D 273		

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D 273	Continued From page 2 -There was a note dated 09/27/19 at 8:30pm documenting the resident was observed " with his fist raised over another resident (female)", stating that the other resident took his snack and ate them while he was away, resident removed from situation and paramedics called to have resident sent out for altered mental status, the resident refused. -There was a note dated 09/28/19 at 1:53am documenting the facility requested for involuntary commitment order on resident on 09/27/19 for attacking resident and it was granted, he was transported to the hospital and a discharge notice was given to the resident. -There was a note dated 09/28/19 at 9:07pm documenting the resident returned from the hospital, he was cooperative and went to the tv room to watch movies. -There was a note dated 10/04/19 at 2:26pm documenting the resident became combative with med tech and other resident, threatening and attempting to become physical. -There was a note dated 10/14/19 at 5:11pm documenting the resident stood and struck a personal care aide, then grabbed her shirt with one hand and attempted to strike aide again. -There was a note dated 01/18/20 at 4:30pm and 5:53pm documenting he had a physical altercation with another resident because [Resident #3] was about to get into a physical altercation with a female resident, Resident #3 was arguing and cursing and grabbed another resident by the collar and threw a punch, resident refused to go to the emergency room for an evaluation. -There was a note dated 02/09/20 at 11:05am documenting the resident was in a physical altercation with a female resident, he was combative with the resident and staff.	D 273		

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	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

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QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

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D 273	Continued From page 3 Review of Resident #3's record revealed: -Resident #3's primary care provider (PCP) was notified via fax on 08/29/19 that the resident "got into a physical altercation with another resident, PCP was notified". -Resident #3's PCP was notified via fax and 09/27/19 that the "resident assaulted another resident". -There was an order dated 10/02/19 for a consultation for a mental health consultation. -There was no other documentation indicating the PCP was notified of the other incidents involving Resident #3. Review of Resident #3's record revealed he had 8 incidents documented of combative, uncooperative, and aggressive behaviors before a psychological consult was ordered by the primary care provider (PCP). Interview with a medication aide (MA)/personal care aide (PCA) on 02/19/20 at 9:27am revealed: -Resident #3 was very combative and there were several incidents she observed and documented in which he tried to grab, punch, or swing at residents and staff. -Resident #3 hit her when she attempted to redirect him out of the laundry room, "he was name calling and aggressive." -She observed the documented incident on 02/09/20 with Resident #3 and a female resident. -She always removed the resident from the situation. -She thought she notified the physician about Resident #3's behaviors after each occurrence, however she did not always document. -She never notified the mental health Nurse Practitioner about Resident #3's behaviors, "they never approached me".	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 4 Interview with a supervisor/MA on 02/19/20 at 9:42am revealed: -Resident #3 got combative at times and he always attempted to keep him calm. -Resident #3 had used profanity towards him, however had never been combative. -Staff had to "tip-toe" around him to avoid confrontation. -When Resident #3 was combative, he never reached out to the mental health provider to notify of changes. Interview with the Resident Care Director (RCD) on 02/19/20 at 10:13am revealed: -She was not working at the facility in October 2019. -Resident #3 was seeing the mental health contracted provider when she began employment. -She, the Resident Care Coordinator (RCC), and the Administrator were responsible for contacting the physician for an order for a mental health consultation after the initial incident of a resident becoming combative. -She knew Resident #3 had behaviors, however thought the resident was getting all required care from the contracted mental health provider. Interview with Resident #3's primary care physician (PCP) on 02/18/20 at 3:30pm revealed: -He knew Resident #3 displayed aggressive combative behaviors. -He referred Resident #3 to for a psychological consultation in October 2019. -He was notified via fax in October 2019 that Resident #2 had "two or three incidents" in September and October 2019 that required a mental health consultation. -He did not know Resident #3 had 8 incidents of combative behaviors prior to ordering a mental	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

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D 273	Continued From page 5	D 273		

health consultation.
-Had he known of the incidents, he would have ordered mental health sooner, so that the resident could get proper treatment.
-He expected the resident to be seen by the mental health provider and for all recommendations to be implemented.
-Since he ordered Resident #3's consultation in October he had not seen the recommendations and he did not know Resident #3's mental health diagnoses.

Interview with Resident #3's mental health nurse practitioner (NP) on 02/19/20 at 12:21pm revealed:
-He first evaluated Resident #3 on 10/11/19 and ordered Depakote 250mg twice daily.
-He saw Resident #3 for an emergency consulation on 10/11/19.
-He was told by a staff member on the day of the initial evaluation, that Resident #3 had a history of being combative with other resident and staff, aggressive, striking residents, and being uncooperative with staff.
-He assessed the resident monthly unless he was called out for an emergency.
-He was not notified of any incidents related to Resident #3's behavior since his initial evaluation.
-He attempted to get an update from staff during his visit in January 2020, however he was unable to speak with staff.
-He expected staff to call the triage number if Resident #3 was displaying behaviors.

Interview with the Administrator on 02/19/20 at 11:22am revealed:
-He was aware Resident #3 displayed combative and aggressive behaviors.
-Resident #3 was saw the mental health provider once ordered by the PCP.

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	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

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QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

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D 273	Continued From page 6 -He did not realize Resident #3 had 8 incidents before a psychological referral was ordered. - "The referral should have been done sooner." -He expected the previous RCC to reach out to the physician to complete the referral timely. 2. Review of Resident #1's current FL2 dated 02/04/20 revealed: -Diagnoses included bipolar and chronic obstructive pulmonary disease. -Resident #1 was ambulatory. -She was continent of bowel and had a suprapubic catheter (A flexible tube in the lower abdominal /pubic region used to drain urine from the bladder). Review of Resident #1's care plan dated 08/14/19 revealed there was documentation Resident #1 could performed catheter care herself. Interview with Resident #1 on 02/19/20 at 9:30am revealed: -She completed catheter care and emptied her catheter drain bag herself. -The facility staff would empty her urine drain bag on night shift, but she did not want the staff doing any site care to her catheter. -The medication aide (MA) were not nurses and she did not want them caring for her catheter. -She said her suprapubic catheter site was leaking, the leaking started about a week ago. -She had not told the facility staff or the Nurse Practitioner (NP) about her catheter site leaking. -She contacted Home Health (HH) on 02/17/20 and asked them to send the nurse out for the leaking around her catheter site. -The HH nurse came out on 02/17/20 and cleaned the catheter site and applied a dressing to the site.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

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D 273	Continued From page 7 -The HH nurse told Resident #1 she would contact the physician about the drainage from the catheter site. -Resident #1 denied pain to the site. Observation of Resident #1's catheter site with staff facility present on 02/19/20 at 9:40am revealed: -There were several 4 X4 gauze around the catheter insertion site secured with paper tape. -There was yellowish-brown drainage about the size of a quarter on the outside of the gauze dressing. -The skin around the suprapubic site was red and there was yellowish-brown drainage around the insertion site. -The suprapubic catheter was secured with one suture connecting Resident #1's skin to the catheter. -The urine bag was secured to Resident #1's right leg and draining clear yellow urine. Interview with a personal care aide (PCA) on 02/19/20 at 9:40am revealed: -She knew Resident #1 had a suprapubic catheter. -Resident #1 could empty her bag and performed all care independently. -Resident #1 completed all personal care on her own. -The PCA would obtain a towel and bathing supplies when Resident #1 took her shower. -She had not provided catheter care to Resident #1 but had emptied her bag on several occasions. -She did not know Resident #1 had leaking around the catheter site. Interview with a medication aide (MA) on 02/19/20 at 10:00am revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 8	D 273		

-She knew Resident #1 had a suprapubic catheter and Resident #1 took care of the catheter herself.
-If Resident #1 complained about her catheter "we send her out".
-She did not know Resident #1's catheter was leaking around the insertion site, or had Resident #1 complained to her about the catheter.

Telephone interview with the HH nurse on 02/19/20 at 12:15pm revealed:
-She had seen Resident #1 on 02/17/20 and assessed her suprapubic catheter.
-She was not the primary nurse following Resident #1's care and services.
-She informed the Resident Care Director (RCD) when entering the facility she was to see Resident #1 for catheter care.
-The RCD had taken her to Resident #1's room but did not stay with her during the examination.
-The tissue around Resident #1's suprapubic catheter was red, and the drainage was a yellowish milky "copious" amount of discharge.
-Resident #1 was afebrile (without a fever).
-The HH nurse cleaned and applied a dressing to the insertion catheter site.
-She had spoken to the RCD and gave a verbal report due of the condition of Resident #1's suprapubic catheter.
-She did not document the visit due to there was no place in the record to document.
-She made the RCD aware of the draining around Resident #1's catheter insertion site.
-She told the RCD she would contact Resident #1's physician.
-She had contacted the physician's office on 02/17/20 and left a message for the physician.

Review of Resident #1's electronic progress note dated 02/17/20 revealed:

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	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

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D 273	Continued From page 9	D 273		

-There was documentation the HH nurse had seen Resident #1 in the facility on 02/17/20.
-There was documentation the HH nurse had informed the RCD to contact the HH nurse if there were any issues regarding Resident #1 catheter.
-The note was created by the RCD on 02/17/20 at 5:19pm.

Telephone interview with the facility Nurse Practitioner on 02/19/20 at 10:10am revealed:
-Resident #1 provided all catheter care herself.
-She was not aware Resident #1's catheter was leaking at the insertion site or that there was yellowish brown drainage.
-She was in the facility on 02/18/20 and would had seen Resident #1 if she had known her suprapubic catheter had drainage around the insertion site.
-The HH nurse never reached out to her on 02/17/20 nor did the facility staff ever inform her on 02/18/20 Resident #1's catheter site had drainage.
-She relied on the facility staff to inform her if residents in the facility needed to be seen.

Interview with the RCD on 02/19/20 at 10:32am revealed:
-She was the RCD and a Licensed Practical Nurse (LPN).
-Her duties were to oversee the clinical staff which included the MAs and the PCAs.
-She knew the HH nurse had seen Resident #1 in the facility on 02/17/20 for catheter site condition.
-She took the HH nurse to Resident #1's room.
-The RCD thought Resident #1's catheter site was "OK", and said "it was intact, looked fine".
-She did not stay with the HH nurse to assess Resident #1's catheter site.
-She did not know Resident #1's catheter site was

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

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D 273	Continued From page 10	D 273		

draining at the insertion site.
-Prior to leaving the facility the HH nurse told the RCD she would contact Resident #1's physician.
-She had not informed Resident #1's facility NP on 02/18/20 that the HH nurse had seen Resident #1 on 02/17/20 for the yellowish-brown drainage at the insertion site of the catheter.
-Resident #1 was not on the NP list for residents in the facility to be seen on 02/18/20.

Telephone interview with the physician office the HH nurse contacted for Resident #1's catheter care on 02/19/20 at 12:32pm revealed Resident #1 as a patient and had not received a call regarding catheter care for Resident #1.

A second interview with Resident #1's NP on 02/20/20 at 9:00am revealed:
-She had seen Resident #1 today 02/20/20.
-She had given a verbal order on 02/19/20 dressing changes daily to Resident #1's insertion site and to apply an antibiotic cream daily.
-Resident #1 would contact the physician's office and HH without informing the facility of the conversations.
-Resident #1 would make appointments with other physicians and not tell the facility or the NP when or why the appointments were made.
-Resident #1 had requested the suprapubic catheter a few months ago, she had a Foley catheter prior to that.
-The NP would schedule an appointment with the urologist to assess the insertion site.

Interview with the Administrator on 02/19/20 at 11:45am revealed:
-He knew Resident #1 had a suprapubic catheter.
-He did not know the HH nurse had seen Resident #1 on 02/17/20 for the drainage around the insertion site of her suprapubic catheter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

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D 273	Continued From page 11 -The RCD was a LPN and should have stayed with the HH nurse to assess Resident #1's drainage to the catheter site. -The RCD was to report to the NP on the next day 02/18/20 when the NP was in the facility or called the NP as soon as the HH nurse saw Resident #1 on 02/17/20. -He expected the RCD to follow up and to complete thorough documentation regarding resident's care and services. -He relied on the RCD to oversee the clinical staff and communicate with the NP for the resident's needs. _____ The facility failed to notify the primary care provider timely for Resident #3, who displayed aggressive, combative, and uncooperative behaviors resulting in the resident hitting and grabbing other residents, getting into verbal altercations putting the safety of other residents at risk. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B violation. _____ A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 02/19/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 5, 2020.	D 273		
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;	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

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D 276	Continued From page 12 and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physician's orders were implemented for 2 of 7 sampled residents related to an order for a continuous positive airway pressure device and orders for physical therapy and occupational therapy (Resident #6), and orders for a referral to a gastroenterologist (Resident #3). The findings are: 1. Review of Resident #6's current FL2 dated 02/12/20 revealed diagnoses included bipolar disorder, anxiety, depression, asthma, restrictive lung disease, shortness of breath, obstructive sleep apnea (OSA), and chronic obstructive pulmonary disease (COPD). a. Review of Resident #6's current FL2 dated 02/12/20 revealed: -There was an order for the use of a continuous positive airway pressure (CPAP) device to be used at night (a CPAP is used for the treatment of obstructive sleep apnea and keeps the airway	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 276	Continued From page 13	D 276		

open during sleep to eliminate breathing pauses).
-There was an order for oxygen (O2) inhale 2 liters/minute (L/min) as needed (PRN).

Review of Resident #6's FL2 dated 02/05/20 revealed:
-There was an order for the use of a CPAP device at night.
-There was an order for O2 inhale 2L/min as needed.

Review of Resident #6's hospital discharge summary dated 02/11/20 revealed:
-Resident #6 was hospitalized from 02/08/20 to 02/11/20 with exacerbation of COPD and medical noncompliance.
-Resident #6 had a recent hospital admission from 01/23/20 to 02/05/20 for COPD exacerbation.

Review of Resident #6's hospital history and physical dated 01/23/20 revealed:
-Resident #6 was admitted to the hospital with COPD exacerbation and acute bronchitis.
-Resident #6's "shortness of breath was likely multifactorial with a history of OSA, COPD, asthma, and obesity hypoventilation syndrome."
-Resident #6 had been unable to use her home CPAP, oxygen, or nebulizer machine in the past month due to living in a homeless shelter.

Review of Resident #6's hospital history and physical dated 02/09/20 revealed:
-Resident #6 was admitted to the hospital with COPD exacerbation on 02/08/20.
-Resident #6's O2 saturation was 85% on room air in the emergency department (ED).
-There was "no improvement on home 2 L/M initially."
-Resident #6 was placed on 5 L/M of O2 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 276	Continued From page 14	D 276		

improvement.
-Resident #6 had a history of noncompliance with wearing her CPAP at night.
-Resident #6 had "a recent hospital admission from 01/23/20 to 02/05/20 for COPD exacerbation. Was discharged to SNF (skilled nursing facility) due to homelessness/lack of resources/patient noncompliance. She reported onset of shortness of breath since discharge, she stated it never improved."

Review of Resident #6's February 2020 electronic medication administration record (eMAR) revealed there was no entry for a CPAP and no documentation the CPAP had been applied.

Observation of the hall where Resident #6's room was located during the initial tour on 02/18/20 from 9:38am to 9:53am revealed:
-Resident #6 was in her room.
-Resident #6 was yelling from her room, "I can't breathe."
-A personal care aide (PCA) went to Resident #6's room to check on her and told the resident she would alert the medication aide (MA).
-The MA and the Resident Care Director (RCD) entered Resident #6's room and closed the door behind them.

Interview with a morning shift MA on 02/19/20 at 9:53am revealed:
-Resident #6 often had a hard time breathing.
-If Resident #6 complained of shortness of breath, she administered her PRN nebulizer treatment.
-Usually the nebulizer treatment was not effective in helping her shortness of breath.
-This morning when she arrived at work (02/19/20), Resident #6 was having a hard time breathing and was very anxious.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 276	Continued From page 15	D 276		

-Resident #6 was wearing her O2.
-"I think she might need a CPAP or something to help her breathe better."

Observation of Resident #6's room on 02/19/20 at 10:20am revealed:
-There was a CPAP machine on Resident #6's nightstand next to her bed.
-Resident #6 was complaining of shortness of breath.
-The Director of the facility's therapy department was in the room with Resident #6 encouraging her to put her oxygen on.
-Resident #6 applied her oxygen.

Interview with Resident #6 on 02/19/20 at 10:20am revealed:
-She was supposed to wear her oxygen as needed, but she wore it all the time "because I need it all the time."
-She experienced shortness of breath every day.
-She had a CPAP device since her admission to the facility (02/05/20).
-She wore her CPAP device every night.
-Facility staff did not assist her with applying the CPAP device or monitor her use of it.

A second interview with Resident #6 on 02/19/20 at 2:40pm revealed:
-Resident #6 was able to apply her CPAP mask "unless she was short of breath."
-She put regular tap water in the CPAP machine.
-No one ever cleaned the CPAP mask, but it was "new."

Interview with a morning shift PCA on 02/19/20 at 2:30pm revealed:
-Resident #6 would "holler and complain all the time about not being able to breathe."
-Resident #6 had rang her call bell at least 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 276	Continued From page 16	D 276		

times on 02/18/20 complaining of shortness of breath.
-She had alerted the MA about Resident #6's complaints.
-She encouraged Resident #6 to wear her O2.
-Resident #6 expressed that her O2 did not help her breathing but did apply it once she encouraged her.
-She generally arrived at work around 6:30am or 7:00am, and Resident #6 would be asleep with her O2 on.
-She had never seen Resident #6 with her CPAP on.

Interview with a second morning shift MA on 02/19/20 at 3:00pm revealed:
-Resident #6 was yelling yesterday (02/18/20) because she wanted a particular inhaler that she did not have an order for.
-She only complained about being short of breath if she was not able to get what she wanted right away.
-She complained often about being short of breath.
-When she complained, he would administer her PRN breathing medications and have her put her O2 on.
-If those interventions did not work, he would alert the RCD, who was a nurse, so she could assess Resident #6 and determine if she needed to go the emergency department (ED).
-He knew Resident #6 had a CPAP device, but he did not know if she used it.
-He did not think Resident #6 had an order for a CPAP.

Interview with an evening shift MA on 02/19/20 at 3:31pm revealed:
-She usually worked until 11:00pm.
-Resident #6 would "holler all night long and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 276	Continued From page 17	D 276		

disturb the other residents."
-Resident #6 had problems with her breathing.
-The RCD was aware of Resident #6's breathing difficulties.
-Resident #6 would sometimes wear her CPAP at night, but not always.
-When Resident #6 wore her CPAP, she applied it herself.
-She did not assist in applying Resident #6's CPAP or document her compliance because there was no order "in the system" for the CPAP.

Interview with the RCD on 02/19/20 at 9:01am revealed:
-She, the Resident Care Coordinator (RCC), and the Administrator were responsible for ensuring physician's orders were implemented.
-She, the Resident Care Coordinator (RCC), and the Administrator were responsible for faxing physician's orders to the pharmacy so the pharmacy could enter the orders onto the eMAR.
-She faxed Resident #6's FL2s to the pharmacy, and she did not know why they did not enter the CPAP on the eMAR.
-She knew Resident #6 complained of breathing difficulties.
-When Resident #6 would complain of being short of breath, she would reinforce the need to wear her O2.
-She did not know Resident #6 had a CPAP in her room.
-She went to Resident #6's room when she needed to be assessed for shortness of breath, but she had never noticed the CPAP in her room.
-She did not know Resident #6 had an order for a CPAP.

Telephone interview with the facility's Account Representative with the contracted pharmacy on 02/20/20 at 10:54am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 276	Continued From page 18	D 276		

-The facility was responsible for faxing medication orders to the pharmacy.
-The pharmacy would then enter the order onto the resident's eMAR, and someone at the facility would have to verify the accuracy of the entry prior to MAs being able to see the order and administer the medication.
-The facility also had access to enter orders onto resident's eMARs.
-In the case of a CPAP, because it was a treatment and not a medication, the pharmacy did not enter those orders on the eMAR.
-It was the facility's responsibility to enter the CPAP on the eMAR so the MAs could document when they applied the CPAP and Resident #6's compliance.

Interview with the Administrator on 02/20/20 at 9:47am revealed:
-He, the RCC, and the RCD were responsible for faxing physician's orders to the pharmacy.
-He did not know why Resident #6's CPAP was not added to the eMAR so the MAs would know to assist her in applying the mask and ensure her compliance.
-He thought staff were supervising the use of Resident #6's CPAP.

Telephone interview with a medical assistant at Resident #6's Primary Care Provider's (PCP) office on 02/20/20 at 11:05am revealed:
-The PCP had not seen Resident #6 in the office since April 2019 until 02/17/20.
-The PCP was not aware Resident #6 had two recent hospitalizations for COPD exacerbations.
-The PCP was not aware Resident #6 had orders from the hospital for a CPAP or O2.
-If Resident #6 was having COPD exacerbations, she would need to use the CPAP and O2 as ordered, to prevent future hospitalizations from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 276	Continued From page 19 occurring. b. Review of Resident #6's current FL2 dated 02/12/20 revealed there was an order for physical therapy (PT) 3 times weekly and occupational therapy (OT) 2 times weekly. Review of Resident #6's hospital history and physical dated 02/09/20 revealed: -Resident #6 was admitted to the hospital with COPD exacerbation on 02/08/20. -Resident #6 was evaluated by PT in the hospital on 02/10/20. -There was documentation by PT, Resident #6 had "decreased activity tolerance, shortness of breath and was at risk for falls." -Resident #6 was evaluated by OT in the hospital on 02/10/20. -There was documentation by OT, Resident #6 had "difficulty performing ADL's (activities of daily living) secondary to poor activity tolerance. Patient would benefit from skilled OT services to increase safety and independence with ADL's and functional mobility. " -Resident #6 was to be "discharged to the Assisted Living Facility (ALF) with PT and OT. Review of Resident #6's record revealed there was no documentation Resident #6 had been referred to PT and OT. Interview with Resident #6 on 02/19/20 at 10:20am revealed: -She could walk to the bathroom (approximately 10 feet from her bed) without assistance, but that was "as far as she could make it." -She would then have to ring her call bell for the staff to provide personal care and help her back to her bed. -She had not been evaluated by OT or PT since	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 276	Continued From page 20	D 276		

her discharge from the hospital (02/11/20).

Interview with the Resident Care Director (RCD) on 02/19/20 at 9:01am revealed:
-She, the Resident Care Coordinator (RCC), and the Administrator were responsible for ensuring physician's orders were implemented.
-She did not notice Resident #6 had an order for PT and OT on her FL2 dated 02/12/20.
-Resident #6 was not receiving PT or OT services.

Interview with the Administrator on 02/20/20 at 9:47am revealed:
-He knew Resident #6 had an order for PT and OT.
-Resident #6's order for PT and OT was on the FL2 she returned with after her discharge from the hospital.
-He was waiting for Resident #6 to establish a PCP so the PCP could complete all required paperwork for the PT and OT referral.
-Resident #6 had a PCP visit on 02/17/20.
-He did not know if anyone had discussed the PT and OT referral with Resident #6's PCP.

2. Review of Resident #3's current FL2 dated 02/04/20 revealed diagnoses included hypertension, cerebral infarction, and chronic kidney disease stage 3.

Review of Resident #3's record revealed:
-There was an order dated 09/11/19 revealed an order for a gastroenterology consultation for a follow-up to Hepatitis C.
-There was no documentation that the gastroenterology consultation was completed.

Interview with the Regional Director of Operations on 02/18/20 at 3:00pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 276	Continued From page 21 -Resident #3 was scheduled for an appointment with the Gastroenterologist, however the appointment was canceled by the practice. -She did not know the date of the previous appointment. -Resident #3 appointment was rescheduled for 02/19/20. Telephone interview with a representative from the Gastroenterology office on 02/18/20 at 3:47pm revealed: -Resident #3 had never been scheduled an appointment for a consultation. -The office never received a referral for Resident #3. -The office received a call from the primary care provider (PCP) on 02/18/20 requesting an appointment on 02/19/20 for a consultation and she was waiting on the referral. Interview with the Resident Care Coordinator (RCC) on 02/20/20 at 10:15am revealed: -She was responsible for scheduling appointments . -She was not the RCC in September 2019, therefore she did not know about Resident #3's gastroenterology referral. -She noticed in the appointment book that Resident #3 had not been to an appointment with the gastroenterologist. -She did not know why the referral for Resident #3 was not implemented. -The PCP scheduled an appointment to be completed on 02/19/20. Interview with the Resident Care Director (RCD) on 02/19/20 at 10:13am revealed: -If an order was received for a consultation referral, the order was faxed to the appropriate office.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 276	Continued From page 22 -The RCC would be responsible for scheduling the appointment. -The PCP could also call and make referrals directly to the appropriate office. -She did not know why Resident #3 had not been seen by gastroenterology. -She thought the appointment was made "a while ago". -She was not the RCD when the order was received and did not know why Resident #3 was not seen until 02/19/20. Interview with the PCP on 02/20/20 at 10:26am revealed: -He ordered Resident #3 to be seen by the gastroenterology specialists for Hepatitis C. -He reviewed some lab work in September 2019 and thought it would be best for him to be seen for treatment. -He expected the resident to be seen within 30 days of writing the order. -He was told by the facility staff on 02/18/20 that Resident #3 had not been seen, therefore he called gastroenterology office himself to get the resident seen. -He was told by the office that the resident was not listed on the profile and he had to resend the referral. Interview with the Administrator on 02/19/20 at 11:22am revealed: -The previous RCC would have been responsible for implementing the order for Resident #3's gastroenterology referral. -The first time he saw the order for a gastroenterology consultation was 02/19/20. -He expected referrals to be implemented immediately after the referral was received. _____	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 276	Continued From page 23 Failure of the facility to implement physician's orders for a CPAP device for Resident #6, who continued to experience shortness of breath, and had multiple hospitalizations for chronic obstructive pulmonary disease (COPD) exacerbations and Resident #3 with orders to be seen by the gastroenterology office specialists for Hepatitis C. These failures were detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/19/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 5, 2020.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 7 sampled residents (Resident #6) rights were maintained and exercised without hindrance. The findings are: Review of Resident #6's current FL2 dated 02/12/20 revealed diagnoses included bipolar disorder, anxiety, depression, asthma, restrictive lung disease, shortness of breath, and chronic	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 338	Continued From page 24 obstructive pulmonary disease (COPD). Review of Resident #6's hospital history and physical dated 02/09/20 revealed: -Resident #6 reported "inadequate care at SNF (skilled nursing facility) and would like to be placed in a different facility." -Resident #6 was "putting up resistance to going back to the skilled nursing facility where she was discharged to previously." Interview with Resident #6 on 02/19/20 at 10:20am revealed: -She was sad and cried all the time due to her living arrangement at the facility. -She was often short of breath and facility staff expected her to do more for herself than she was physically capable of doing. -Staff would say "you can do that yourself" regarding personal care. -The night before (02/18/20), the evening shift medication aide (MA) had brought her medication into her room. -The MA found out she had attempted to file a formal complaint against her and the facility. -The MA told Resident #6 "I'll fix this [expletive], I'll get your [expletive] out of here." -The MA then threw the cup containing Resident #6's medications at her and left the room. -The medications landed in the floor so Resident #6 did not take them. -Another resident across the hall came over and picked the medication up off the floor and threw them in her trash. Interview with another resident on 02/19/20 at 10:30am revealed: -Resident #6 often yelled out because she had trouble breathing and staff did not like that. -He had witnessed staff getting angry with	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 338	Continued From page 25	D 338		

Resident #6 and yelling at her.
-He heard Resident #6 and the evening shift MA arguing and cussing at each other the night before (02/18/20).
-Once the MA left the room, he went into Resident #6's room to check on her.
-He observed her medications on the floor.
-He picked the medications up and threw them in Resident #6's trash as she requested.

Review of Resident #6's February 2020 electronic medication administration record (eMAR) revealed:
-On 02/18/20, there was documentation Resident #6 refused the following evening medications: buspirone (a medication used to treat anxiety), ferrex 150 (an iron supplement), melatonin (a medication used for sleep), metoprolol succinate (a medication used to treat high blood pressure), and trazodone (a sedative medication used to treat depression).
-On 02/18/20 at 8:24pm, there was documentation Resident #6 was administered as needed (PRN) alprazolam for anxiety (a sedative medication used to treat anxiety and panic disorder).
-On 02/19/20 at 1:07am, there was documentation Resident #6 was administered PRN alprazolam for anxiety.

Interview with an evening shift MA on 02/19/20 at 3:31pm revealed:
-Resident #6 would "holler all night long and disturb the other residents."
-On 02/18/20, Resident #6 began yelling from her room.
-She went to Resident #6's room to ask what she needed, and Resident #6 wanted her evening medications.
-She told Resident #6 she would have to wait until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 338	Continued From page 26	D 338		

she administered medications to each resident standing at her medication cart, and she left the room.
-Resident #6 continued to yell, so she went back to her room and closed her door so she would not disturb the other residents.
-When she left the room, she could hear Resident #6 throwing items against her door.
-Once she had finished administering medications to the residents at her medication cart, she went to Resident #6's room to administer her medications.
-She placed all Resident #6's medications into a cup and entered her room.
-Resident #6 was upset with her because she had to wait for her medications and cussed at her.
-She did not cuss at Resident #6.
-Resident #6 refused all medications other than her PRN alprazolam.
-She did not know anything about medications being on Resident #6's floor.
-She wasted all of Resident #6's refused medications in the sharps container on her medication cart.

Interview with the Resident Care Director (RCD) on 02/20/20 at 9:01am revealed:
-She was aware of the incident between the evening shift MA and Resident #6 that occurred on 02/18/20.
-Resident #6's family member had contacted the RCD to complain about Resident #6 not being able to get her medication in a timely manner.
-When the RCD addressed the issue with the MA, the MA told her Resident #6 was upset because she could not get her medications at the exact time she wanted them.
-"She's (Resident #6) like a big baby and starts yelling if she doesn't get what she wants."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 338	Continued From page 27 -She did not know Resident #6's medications ended up on the floor, and she did not know how it would have occurred unless Resident #6 "threw them herself." Interview with the Administrator on 02/20/20 at 10:17am revealed: -He was not aware of the incident that occurred between the MA and Resident #6. -Facility staff had attended a mandatory resident rights training on 02/07/20. -Facility staff had attended a mandatory training in January 2020 with the facility's mental health provider regarding how to handle a resident's anger. -He expected staff to incorporate what they learned in both trainings.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 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. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 7 sampled residents Resident #3 including a medication used to treat mood disorders, Resident #1 an	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 358	Continued From page 28	D 358		

opioid pain medication, and Resident #6's NicoDerm patch.

The findings are:

1. Review of Resident #3's current FL2 dated 02/04/20 revealed diagnoses included hypertension, cerebral infarction, and cognitive communication deficit.

Review of Resident #3's Resident Register revealed he was admitted on 07/30/19.

Review of a psychotherapy progress note dated 01/08/20 revealed Resident #3's diagnoses included unspecified mood disorder, unspecified dementia with behavioral disturbance, and paranoid schizophrenia.

Review of a physician's order dated 10/11/19 revealed Depakote 250mg twice daily (used to treat mood disorders) for mood and behaviors.

Review of Resident #3's December 2019 electronic medication administration record (eMAR) revealed:
-There was no entry for Depakote 250mg twice daily.
-There was no documentation Depakote had been administered as ordered.

Review of Resident #3's January 2020 eMAR revealed:
-There was no entry for Depakote 250mg twice daily.
-There was no documentation Depakote had been administered as ordered.

Review of Resident #3's February 2020 eMAR revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 358	Continued From page 29 -There was no entry for Depakote 250mg twice daily. -There was no documentation Depakote had been administered as ordered. Observation of Resident #3's medications available for administration on 02/18/20 at 12:57pm revealed there was no Depakote 250mg available for administration. Interview with the pharmacist at the contracted pharmacy for Resident #3 on 02/18/20 at 2:46pm revealed: -Orders were received via fax from the facility. -When the order was received, the medication was filled within 24 hours. -The pharmacy had not received an order for Depakote 250mg for Resident #3 dated 10/11/19. -The pharmacy never dispensed Depakote 250mg for Resident #3. Review of Resident #3's progress notes revealed: -On 07/31/19 at 10:57pm the resident had an altercation with another resident that led to being physical. -On 08/02/19 at 2:40pm the resident was combative towards roommate, he was moved to a different room. -On 08/06/19 at 10:17pm and 10:25pm the resident became upset because he did not want to wait for the medication aide to administer his medication, he was asked to wait as the medication aide was passing out medications to another resident, the resident stood up out of his wheelchair and threatened to slap the medication aide in the face. -On 08/18/19 at 9:41am the resident was combative towards roommate, the med tech and manager on duty stepped in, executive director instructed staff to send resident for a	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 358	Continued From page 30	D 358		

psychological evaluation, he was transported to the hospital.
-On 08/29/19 at 7:11pm the resident provoked a physical altercation in the hallway with another resident, the resident was stopped in the middle of the hallway hitting and cursing the other resident in the face.
-On 09/27/19 at 8:30pm the resident was observed " with his fist raised over another resident (female)", stating that the other resident took his snacks and ate them while he was away, resident removed from situation and paramedics called to have resident sent out for altered mental status, the resident refused.
-On 10/04/19 at 2:26pm documenting the resident became combative with med tech and other resident, threatening and attempting to become physical.
-On 10/14/19 at 5:11pm documenting the resident stood and struck personal care aide then grabbed her shirt with one hand and attempted to strike aid again.
-On 01/18/20 at 4:30pm and 5:53pm documenting there was a physical altercation with another resident because [Resident #3] was about to get into a physical altercation with a female resident, Resident #3 was arguing and cursing and grabbed another resident by the collar and threw a punch, resident refused to go to the emergency room for an evaluation.
-On 02/09/20 at 11:05am the resident was in a physical altercation with a female resident, he was combative with the resident and staff.

Interview with the medication aide (MA) on 02/20/20 at 9:45am revealed:
-Medications were administered according the eMAR.
-MAs were not responsible for processing medication orders or entering them on the eMAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 358	Continued From page 31 -The Resident Care Coordinator (RCC) and Resident Care Director (RCD) were responsible for processing orders and ensuring medications were entered on the eMAR. -She did not see an order on the eMAR to administer Depakote 250mg twice daily for Resident #3. Interview with the RCC on 02/20/20 at 10:09am revealed: -She did not frequently process orders for the facility. -If she entered orders, it was under the direct guidance and supervision of the RCD or Administrator. -She had not seen an order for Resident #3's Depakote 250mg. -When she received orders, she normally gave the order to the RCD. Interview with the RCD on 02/19/20 at 10:13am revealed: -She, the RCC, and Administrator were responsible for sending medication orders to the pharmacy immediately after received from the physician. -Once the order in entered into the eMAR system it is approved by her, the RCC, or the Administrator. -She did not remember seeing the Depakote 250mg order for Resident #3 until 02/18/20 while browsing through the record. -She was not working at the facility in October 2019, therefore she would not have processed the order. -She did not know the Depakote 250mg order was never sent to the pharmacy for Resident #3. -She knew Resident #3 had behaviors, however thought the resident was getting all required care from the contracted mental health provider.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 358	Continued From page 32 Interview with Resident #3's primary care physician (PCP) on 02/18/20 at 3:30pm revealed: -He knew Resident #3 displayed aggressive combative behaviors. -He referred Resident #3 to for a psychological consultation in October 2019. -He expected the resident to be seen by the mental health provider and for all recommendations to be implemented. -He did not know of any medications ordered by the mental health provider. -He did not know Resident #3's mental health diagnosis, therefore he had not prescribed any medications for mood disorder. Interview with Resident #3's Psychologist on 02/19 at 10:37am revealed: -He had been seeing Resident #3 since December 2019. -He knew Depakote 250mg was ordered for Resident #3 on 10/11/19. -The Depakote should have been tried to see if it would help stabilize his mood. -He would keep the Resident #3 been on a mood stabilizer for optimal therapy. Interview with Resident #3's mental health nurse practitioner (NP) on 02/19/20 at 12:21pm revealed: -He first evaluated Resident #3 on 10/11/19 and ordered Depakote 250mg twice daily. -The Depakote was ordered to help stabilize behaviors associated with mood disorder. -He expected the resident to receive medication as ordered, he had not discontinued the Depakote. -The resident had a history of being combative with other resident and staff, aggressive, striking residents, and being uncooperative with staff.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 358	Continued From page 33	D 358		

-Without the Depakote to stabilize Resident #3's mood, he could be a threat to the safety of other residents and staff.

Interview with the Administrator on 02/19/20 at 11:22am revealed:
-Medication orders were to be sent to the pharmacy immediately when received from the physician.
-The previous RCC would have been responsible for sending the order to the pharmacy.
-The first time he saw the Depakote order for Resident #3 was 02/19/20.
-He did not know Resident #3 had not received the Depakote as ordered.

2. Review of Resident #1's current FL2 dated 02/04/20 revealed:
-Diagnoses included bipolar and chronic obstructive pulmonary disease.
-A medication order for oxycodone 10mg (an opioid pain medication used for moderate to severe pain) one tablet five times daily.

Observation on 02/18/20 at 2:38pm of medication on hand for Resident #1 revealed there were 4 oxycodone 10mg tablets available for administration.

Review of Resident #1's December 2019 and January 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for oxycodone 10mg five times daily scheduled at 6:00am, 10:00am, 2:00pm, 6:00pm and at 10:00pm.
-There was documentation oxycodone 10mg was administered in December 2019 and in January 2020 five times daily as ordered.

Review of Resident #1's February 2020 eMAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 358	Continued From page 34	D 358		

revealed:
-There was an entry for oxycodone 10mg five times daily scheduled at 6:00am, 10:00am, 2:00pm, 6:00pm and at 10:00pm.
-There was documentation oxycodone 10mg was administered February 1st through the 18th at 6:00am five times daily as ordered.
-There was no documentation oxycodone 10mg was administered on February 18th at 10:00am, 2:00pm, 6:00pm, 10:00pm or on February 19th at 6:00am or at 10:00am.

Observation on 02/19/20 at 9:10am of medication on hand for Resident #1 revealed there were no oxycodone 10mg tablets available for administrating.

Interview on 02/19/20 at 9:30am with the medication aide (MA) revealed:
-Resident #1's oxycodone 10mg was "DC'd" yesterday.
-The RCD told her Resident #1's oxycodone was discontinued by the Nurse Practitioner (NP) on 02/18/20.
-She did not administer Resident #1's oxycodone 10mg yesterday at 2:00pm or today at 10:00am.

Interview on 02/19/20 at 9:10am with Resident #1 revealed:
-The facility staff "DC'd" my oxycodone yesterday.
-"I know the NP would not discontinue it because she talked to me about not drinking alcohol and taking my oxycodone."
-Resident #1 met with the NP and agreed not to drink alcohol if she would not stop the pain medication used for her back pain.
-"The staff just stopped it themselves."

Telephone interview on 02/19/20 at 10:10am with Resident #1's NP revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 358	Continued From page 35 -She knew Resident #1 had orders for oxycodone 10mg scheduled five times daily. -The oxycodone was used to control Resident #1's pain. -She had not ordered the oxycodone 10mg to be discontinued on 02/18/20. -She had supplied the facility with a refill prescription on 02/18/20 for Resident #1's oxycodone 10mg. -She would never "Cold Turkey" a resident off oxycodone. -The resident would need to be tapered or weaned off oxycodone, not abruptly stopped. -The side effects of stopping oxycodone abruptly could lead to withdrawals. Interview on 02/19/20 at 10:25am with the RCD revealed: -The facility was going to electronic charting, so all orders were to be scanned into the computer system. -She was responsible for all new orders and to ensure the orders were scanned into the electronic computer system. -She had an order on file from the NP on 02/18/20 to discontinue Resident #1's oxycodone 10mg. -She told the MA on 02/18/20 Resident #1's oxycodone 10mg was discontinued. -She could not locate the order to discontinue the oxycodone 10mg for Resident #1 on the computer system. Telephone interview with the facility contract pharmacy revealed: -Resident #1 had a current order for oxycodone 10mg one tablet five times daily. -The order for the oxycodone 10mg was filled on 02/18/20 dispensing 150 tablet to the facility. -The courier delivered Resident #1's oxycodone	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 358	Continued From page 36	D 358		

10mg to the facility at 9:30pm on 02/18/20.
-Oxycodone could not be stopped abruptly, it must be tapered, or the dose be reduced gradually.
-The resident would need wean off the oxycodone gradually for several weeks.
-If stopped abruptly the complications could be severe pain, muscle spasms, GI complications and suicide ideations.

Interview on 02/19/20 at 11:45am with the Administrator revealed:
-He knew the RCD had said there was an order to discontinue Resident #1's oxycodone 10mg on 02/18/20.
-The RCD thought the oxycodone 10mg for Resident #1 was discontinued on 02/18/20.
-"It was discontinued by accident."
-The RCD told the MA Resident #1 oxycodone 10mg was discontinued, and the MAs told Resident #1.
-There was no order to discontinue oxycodone 10mg for Resident #1.
-He relied on the RCD to oversee the new order process.

Observation on 02/19/20 at 11:45am of Resident #1's medication the Administrator had brought to the survey team revealed there where 150 tablets of oxycodone 10mg in 4 bubble packs with pharmacy generated labels.

Review of the eMAR for February 2020 on 02/19/20 at 2:10pm revealed Resident #1's oxycodone 10mg was administered on 02/19/20 at 2:00pm.

3. Review of Resident #6's current FL2 dated 02/12/20 revealed:
-Diagnoses included bipolar disorder, anxiety,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 358	Continued From page 37	D 358		

depression, asthma, restrictive lung disease, shortness of breath, and chronic obstructive pulmonary disease (COPD).
-A medication order for NicoDerm CQ 21mg/24 hours (a medication used to aid in quitting smoking) place one patch onto skin daily.

Review of Resident #6's February 2020 electronic medication administration record (eMAR) from 02/12/20-02/20/20 revealed:
-There was no entry for NicoDerm CQ.
-There was no documentation NicoDerm CQ had been administered to Resident #6 on 9 of 9 opportunities.

Observation of Resident #6's medications available for administration on 02/19/20 at 9:53am and 02/20/20 at 10:05am revealed there were no NicoDerm CQ patches available for administration.

Review of Resident #6's hospital discharge summary dated 02/11/20 revealed:
-Resident #6 was hospitalized from 02/08/20 to 02/11/20 with exacerbation of COPD and medical noncompliance.
-Resident #6 had a recent hospital admission from 01/23/20 to 02/05/20 for COPD exacerbation.
-Resident #6 was on 2 liters/minute (L/M) oxygen (O2) and was actively smoking.
-Resident #6 was "noted by RN (Registered Nurse) to be actively smoking in her hospital room."
-Resident #6 should "avoid smoking or being around smoke to manage her overall health at home."

Interview with a morning shift medication aide (MA) on 02/19/20 at 9:53am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

(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 358	Continued From page 38	D 358		

-Resident #6 had a hard time breathing.
-When she came into work this morning (02/19/20), Resident #6 was yelling that she was having a difficult time breathing and was very anxious.
-Resident #6 continued to go outside and smoke daily.
-Resident #6 did not have an order for NicoDerm CQ patches.

Telephone interview with a pharmaceutical technician at the facility's contracted pharmacy on 02/20/20 at 9:54am revealed:
-The pharmacy received an order for Resident #6's NicoDerm CQ patches apply one patch daily on 02/12/20.
-She did not know why the NicoDerm CQ was not on Resident #6's eMAR.
-The pharmacy dispensed 30 NicoDerm CQ patches for Resident #6 on 02/13/20.

Interview with an evening shift MA on 02/20/20 at 10:05am revealed:
-She saw NicoDerm CQ patches for Resident #6 in the medication room, but she could not find them now.
-NicoDerm CQ had not been placed on the medication cart for administration to Resident #6 because there was no entry on the eMAR, and the patches could not be administered to Resident #6 until they were on the eMAR.
-The Resident Care Coordinator (RCC) was aware there was no entry on the eMAR for Resident #6's NicoDerm CQ patches.

Interview with the RCC on 02/20/20 at 10:11am revealed:
-She did not know anything about Resident #6's NicoDerm CQ patch.
-The MA was mistaken about another resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUEEN CITY ASSISTED LIVING	1700 MONTNAN DRIVE CHARLOTTE, NC 28216

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D 358	Continued From page 39 nicotine gum. Interview with Resident #6 on 02/20/20 at 10:33am revealed: -She was trying to quit smoking because her physician had recommended she do so to help her breathing. -She had not been administered NicoDerm CQ patches. -She was still smoking. Telephone interview with the facility's Account Representative with the contracted pharmacy on 02/20/20 at 10:54am revealed: -The facility was responsible for faxing medication orders to the pharmacy. -The pharmacy would then enter the order onto the resident's eMAR, and someone at the facility would have to verify the accuracy of the entry prior to MAs being able to see the order and administer the medication. -The facility also had access to enter orders onto resident's eMARs. -She did not know why there was no entry on Resident #6's eMAR for NicoDerm CQ patches. -The pharmacy received the order for Resident #6's NicoDerm CQ patches apply 1 patch daily on 02/12/20. -The patches were on backorder for one day on 02/12/20. -The pharmacy dispensed 30 NicoDerm CQ patches for Resident #6 on 02/13/20. Telephone interview with a medical assistant at Resident #6's Primary Care Provider's (PCP) office on 02/20/20 at 11:05am revealed: -The PCP had last seen Resident #6 in the office on 02/17/20. -The PCP was not aware Resident #6 had two recent hospitalizations for COPD exacerbations.	D 358		

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	HAL060126	A. BUILDING: _____ B. WING _____	C 02/20/2020

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D 358	Continued From page 40 -It was important for Resident #6 to have the daily NicoDerm CQ patches to aid her in quitting smoking and to help prevent future hospitalizations for shortness of breath and COPD. Interview with the Administrator on 02/20/20 at 9:47am revealed: -He did not know Resident #6 did not have NicoDerm CQ patches available for administration. -It was the RCD and RCC's responsibility to ensure medications were available for administration. _____ The facility failed to administer medications as ordered for Resident #3 who was ordered Depakote 250mg twice daily for mood and behaviors on 10/11/19, the medication was never administered resulting in increased behaviors, multiple altercations with residents and staff, combative towards roommate, and risk of serious physical harm to multiple residents; Resident #1 was not administered oxycodone for 5 consecutive doses because staff discontinued it without an order to do so which increased the risk for increased severe pain, gastrointestinal complications, and suicidal ideation. The failure of the facility to ensure medications were administered as ordered put the residents at risk for serious physical harm and constitutes an A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/19/20 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 21,	D 358		

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D 358	Continued From page 41 2020.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews the facility failed to report Staff E, a personal care aide, to the healthcare personnel registry (HCPR) for an allegation related to theft. The findings are: Review of a facility "grievance report" dated 02/03/20 revealed: -The Administrator had completed the report. - A "resident complained that someone took his money." -"Two staff members were interviewed regarding the stolen money when they were in his room giving his roommate a shower. No sufficient evidence established through an interpreter." -The Administrator had given the resident $40.00. Review of Resident #2's current FL-2 dated 02/15/20 revealed: -Diagnoses included disorder of kidney and	D 438		

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D 438	Continued From page 42	D 438		

ureter, hypertension, suicidal ideation, vitamin epistaxis, constipation, chronic obstructive pulmonary disorder, anxiety disorder, hyperlipidemia, hypokalemia, and major depressive disorder.
-There was no diagnosis of dementia.

Review of the resident's progress note dated 02/03/02 at 10:44am revealed:
-The resident reported to a staff person, who spoke Spanish, that someone stole his money on 02/03/20.
-The staff told the Administrator the resident had money, he needed, stolen.
-The Administrator gave the resident $40.00.
-The Administrator spoke to the 2 staff who were in his room assisting the resident's roommate with a shower.
-The staff reported the resident was angry with them about having to wait to enter his room, and then he said that someone had taken his money.
-The Administrator told the resident his complaint was looked at, but it could not be substantiated.

Interview with Administrator on 02/19/20 at 12:15pm revealed:
-A resident had accused Staff E of taking his money while 2 staff members were giving his roommate a bath.
-The resident claimed [Staff E] had "picked the lock" on his nightstand drawer and stolen $190 from him.
-The Administrator had immediately begun an investigation by interviewing the staff members who bathed the resident roommate at the time the allegation occurred.
-He "was not sure" why the resident had accused only [Staff E] and not the other staff member of stealing money from him.
-He was unable to determine if either staff

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D 438	Continued From page 43 member in his room at the time of the incident had taken any money from the Resident. -The resident frequently loaned money to other residents or gave other residents money to buy something for him at the store. -The resident would then come the Administrator upset because the other residents had not given him any money back. -The Administrator frequently had to intervene on these occasions to help the resident get his money back. -The resident had never accused a staff member of stealing money prior to this incident. -He gave the resident $40.00 of his own money because he felt bad about the situation. -The two staff were allowed to continue to work since he was unable to determine if any money had been stolen. -He did not report the incident to the Health Care Personnel Registry for the staff member the resident accused of stealing $190 because he was not able to substantiate that a staff member had taken the money. -He was not aware any allegations against staff were required to be reported to the health care registry regardless of whether the allegation was substantiated. -He did not notify the police of Resident #2's allegation. Observation of the resident room on 02/12/20 at 1:35pm revealed: -The lockable drawer in his bedside table was damaged and had some splintering wood around the lock. -The resident had his empty urinal bottle hooked over the top of the drawer, which prevented the drawer from closing or locking at the time of observation.	D 438		

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D 438	Continued From page 44 Interview with a medication aide (MA) on 02/19/20 at 10:25am revealed: -The only incident the staff member knew of regarding anything being stolen by staff from a resident occurred a few weeks ago when a resident accused [Staff E] of stealing his money. -The resident had never falsely accused anyone of taking his belongings or money in the past. -The resident did often loan money to other residents and would then get upset when they did not pay him back, but he had never falsely accused any staff members of stealing from him. Resident #2 was not available for interview during the investigation. _____ The facility failed to report (Staff E) to the HCPR for an allegation of missing money (190.00) a resident reported to the Administrator. The failure of the facility to ensure staff were reported to the HCPR was detrimental to the safety and welfare of all residents and constitutes a Type B violation The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 2/19/2020 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 5, 2020.	D 438		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and	D912		

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D912	Continued From page 45 regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to healthcare referral and follow-up, medication administration, health care personnel registry and health care implementation. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up for 2 of 7 sampled residents regarding notifying the physician for drainage from the insertion site of a suprapubic catheter (Resident #1) and regarding a delayed referral for a mental health consultation (Resident #3). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to ensure physician's orders were implemented for 2 of 7 sampled residents related to an order for a continuous positive airway pressure device and orders for physical therapy and occupational therapy (Resident #6), and orders for a referral to a gastroenterologist (Resident #3). [Refer to Tag 276, 10A NCAC 13F .0902(c) (4) Health Care (Type B Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 7 sampled residents Resident #3 including a medication	D912		

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D912	Continued From page 46 used to treat mood disorders, Resident #1 an opioid pain medication, and Resident #6's NicoDerm patch. [Refer to Tag 338, 10A NCAC 13F .1004 (a) Medication Administration (Type A2 Violation).] 4. Based on record reviews and interviews the facility failed to report Staff E, a personal care aide, to the healthcare personnel registry (HCPR) for an allegation related to theft [Refer to tag 438,10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation).]	D912		