STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060158	A. BUILDING: _____ B. WING _____	R-C 03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHARLOTTE ASSISTED LIVING	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 03/09/21 to 03/10/21.	{D 000}		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents (#3) for obtaining a stool specimen. The findings are: Review of Resident #3's current FL2 dated 12/17/20 revealed diagnoses included altered mental status, chronic kidney disease stage 1, delirium, vitamin D deficiency, hypokalemia. Review of a physician's order for Resident #3 dated 03/01/21 revealed an order to obtain a stool specimen for clostridium difficile colitis (C. diff)	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060158	A. BUILDING: _____ B. WING _____	R-C 03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHARLOTTE ASSISTED LIVING	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 1 (bacteria in the colon which causes inflammation). Review of the Resident #3's progress notes revealed: -On 03/04/21, there was documentation staff were unsuccessful in obtaining the stool specimen. -On 03/06/21, there was documentation staff were unable to obtain the stool sample. Observation of Resident #3's room on 03/10/21 at 12:15pm revealed: -There were several toilet hat specimen collectors located in the bathroom. -There was a container with a plastic bag above the toilet. -There were no instructions with the container or plastic bag. Interview with a personal care aide (PCA) on 03/10/21 at 3:00pm revealed: -Resident #3's stool was always loose, and it was hard to collect. -She assisted Resident #3 to the toilet every 2 hours and allowed the resident to pass stool in the toilet hat. -Resident #3's stool and urine were normally passed together and it made it difficult to collect the stool. -She told the Resident Care Coordinator (RCC) when the stool and urine were passed together and the RCC instructed her to keep trying. -Each time Resident #3's stool and urine were passed together, she did not allow the RCC or Resident Care Director (RCD) to see the stool, and she would discard because she did not think it was viable. -Resident #3 had a bowel movement in her pull-up on 03/09/21, however she did not know if	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060158	A. BUILDING: _____ B. WING _____	R-C 03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHARLOTTE ASSISTED LIVING	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 2	{D 276}		

she could collect the stool from Resident #3's brief.
-She had not been instructed to collect it from the brief.
-She never asked it she could collect the stool from the brief because she was following the instructions as given by the RCC.
-She did not know how much stool was supposed to be collected and placed in the container.

Interview with a second shift PCA on 03/10/21 at 3:20pm revealed:
-He last worked on 03/06/21 in the special care unit (SCU).
-He provided care to Resident #3 when he worked.
-On 03/06/21, Resident #3 had a large bowel movement which he cleaned.
-He did not collect Resident #3's stool because he did not know the resident had an order for the stool to be collected.

Interview with a PCA on 03/10/21 at 2:35pm revealed:
-Resident #3 last had a bowel movement on 03/09/21 during first shift according to the personal care log.
-Another PCA documented the bowel movement, she was not sure why the stool was not collected.

Interview with a medication aide (MA) on 03/10/21 at 2:30pm revealed:
-She attempted and the PCAs had been trying to collect Resident #3's stool since the order was received on 03/01/21.
-There had attempted every two hours to collect stool from Resident #3.
-The container to collect the stool was above Resident #3's toilet.
-She and the PCAs were taking the resident to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060158	A. BUILDING: _____ B. WING _____	R-C 03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHARLOTTE ASSISTED LIVING	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 3	{D 276}		

the bathroom every 2 hours, however the resident did not always have bowel movement, or the stool was too loose to collect.

Telephone interview with the Hospice Nurse on 03/10/21 at 11:34am revealed:
-Resident #3 had issues with loose stools.
-The primary care physician (PCP) wanted to rule out C. diff, so that another medication could be prescribed to help with loose stools.
-She last visited the facility on 03/08/21 and staff informed her that Resident #3 had a bowel movement, however the stool was not collected.
-She received a phone call from the RCC about discontinuing the order, however the PCP wanted the order to continue.

A second telephone interview with the Hospice Nurse on 03/10/21 at 3:35pm revealed:
-Resident #3's stool could be collected from the toilet hat or from the brief.
-There were two licensed nurses in the building (RCD and RCC) who she thought would be able to ensure a stool sample could be collected.
-Resident #3 was incontinent majority of the time and if the stool was solid, it would be appropriate to come from the brief.
-If the stool was not saturated with urine, the stool could be collected and submitted, because the bacteria that is being tested would still be present in the stool.

Interview RCC on 03/10/21 at 4:00pm revealed:
-She knew Resident #3 had an order to collect a stool specimen dated 03/01/21.
-She verbally notified the first and second shift MAs and PCAs of the need to collect the stool when the order was initially received.
-The MAs and PCAs were responsible to notifying the other shifts to collect the stool from Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060158	A. BUILDING: _____ B. WING _____	R-C 03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHARLOTTE ASSISTED LIVING	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 4 #3. -Information about the resident was communicated via a verbal shift-to-shift report. -She was informed several times by PCAs and MAs that Resident #3's stool was too loose and often had urine combined which was not viable. -The MAs and PCAs did not show her the stool each time because she was not in the building at all times. -The MAs and PCAs were competent enough to collect a stool specimen. -There were no written instructions or training provided to MAs or PCAs for collecting stool specimens. Interview with the Resident Care Director (RCD) on 03/10/21 at 3:30pm revealed: -She oversaw the clinical staff in the facility. -She did not know Resident #3 had an order to collect a stool specimen dated 03/01/21. -The RCC informed her yesterday (03/09/21) that the staff in the SCU had been unsuccessful with collecting the stool due to its consistency. -She expected the MAs or PCAs to collect the stool by putting the resident on the toilet with a toilet hat placed to collect the stool. -There were no written instructions or training provided to the staff regarding collecting a stool sample. -She expected the MAs and PCAs to be able to collect the stool and place it in the container. -There was no specific amount of stool to be collected, the MAs and PCAs were supposed to place the stool in the container and provide for the Hospice Nurse. Interview with the Administrator on 03/10/21 at 4:15pm revealed: -She expected orders to be implemented once received from the PCP.	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060158	A. BUILDING: _____ B. WING _____	R-C 03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHARLOTTE ASSISTED LIVING	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 5 -The RCC was responsible for informing staff in the SCU of orders and making sure that they were completed. -She did not know if all the MAs and PCAs knew how to collect the stool specimen. -She expected the RCC and RCD to provide clear instructions on when and how to collect the stool specimen.	{D 276}		