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 _____	C 10/26/2021

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 and the Mecklenburg County Department of Social Services conducted an annual survey and a state involved complaint investigation survey with onsite visits 10/19/21 to 10/22/21, a desk review on 10/25/21 and with a telephone exit conference on 10/26/21. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 10/06/21.	D 000		
D 229	10A NCAC 13F .0702 (e) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (e) The facility shall assure the following requirements for written notice are met before discharging a resident: (1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Medical Assistance, 2505 Mail Service Center, Raleigh, NC 27699-2505. (2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative on the same day the Adult Care Home Notice of Discharge is dated. (3) Failure to use and simultaneously provide the specific forms according to Subparagraphs (e)(1) and (e)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge unless the facility has been previously notified of	D 229		

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 _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 229	Continued From page 1	D 229		

a change in the forms and been provided a copy of the latest forms by the Department of Health and Human Services.
(4) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

This Rule is not met as evidenced by:
Based on interviews and record review, the facility failed to request a receipt upon issuing a discharge notice to 1 of 5 sampled residents (Resident # 1) that was discharged to home.

The findings are:

Review of Resident #1's current FL2 dated 08/09/2021 revealed:
-Diagnosis included Alzheimer's dementia, history of falls, idiopathic hydrocephalus, abnormal gait, glaucoma, diabetes mellitus, and hypertension.
-A recommended level of care was not listed.

Review of Resident #1's Notice of Discharge dated 10/15/2021 revealed:
-The planned discharge date listed 10/15/2021.
-The reason for discharge listed the resident's health or safety was endangered, and the resident's urgent medical needs could not be met in the facility.
-The planned discharge location listed options for one assisted living facility and one Special Care Unit.

Review of Resident #1's Adult Care Home Hearing Request Form revealed:

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 _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 229	Continued From page 2	D 229		

-The date of transfer or discharge notice was dated 10/15/2021.
-The date of scheduled transfer or discharge was dated 10/15/2021.

Review of Resident #1's Resident Register revealed:
-Resident #1's responsible party was listed.
-There was no documented discharge or transfer information.

Review of Resident # 1's physician's orders record revealed a physician's order dated 08/20/2021 with a recommended level of care for assisted living.

Review of Resident #1's progress notes revealed:
-Resident #1 was admitted to the facility on 08/20/2021.
-There was no documentation that Resident # 1's level of care had changed.
-There was no documentation that the facility had attempted to determine if the resident's level of care had changed since 08/20/2021.

Review of facility's undated discharge policies and procedures revealed the facility will give the Notice of Discharge and the Hearing Request Form to the resident, responsible person, or legal representative on the same day the Notice of Discharge is dated.

Based on record review and interviews, it was determined Resident #1 was not interviewable.

Interview with Resident #'1's responsible party on 10/20/2021 at 1:00pm revealed:
-She was the legal representative for Resident #1.
-Resident #1's physician recommended 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 _____	C 10/26/2021

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

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D 229	Continued From page 3 #1 move to an assisted living facility. -On 10/15/2021, she received an email from the facility informing her that Resident #1 would be discharged effective 10/15/2021. -The facility notified her that Resident #1 was immediately discharged on 10/15/2021 because the facility could no longer meet the Resident #1's needs. -On 10/15/2021, she did not know the location where Resident #1 was to be discharged too. -On 10/15/2021, Resident #1 was sent on a Special Transportation Services (STS) bus at approximately 7:30am to Resident #1's adult day care center. -She did not know if Resident #1 had been issued a Notice of Discharge or Hearing Request form. Interview with the Executive Director on 10/22/2021 at 10:22am revealed: -Resident #1 was admitted to the facility on 08/20/2021. -Resident #1 attended an adult day care center every weekday. -She had determined the facility could no longer meet Resident #1's needs due to concerns Resident #1's needed increased supervision. -On 10/15/2021, at approximately 7:30am she issued an immediate discharge to Resident #1 because Resident #1's physician refused to increase Resident #1's level of care to Special Care Unit (SCU). -On 10/15/2021 she handed Resident #1 a Notice of Discharge and Hearing Request Form with a discharge date listed as 10/15/2021 while Resident #1 was getting on a bus to attend adult daycare. -She did not request a receipt from Resident #1 upon delivery of Resident #1's Notice of Discharge. -The Notice of Discharge listed two facilities that	D 229		

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 _____	C 10/26/2021

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

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D 229	Continued From page 4 agreed to admit Resident #1 on 10/15/2021. -She was not aware of the two facilities listed on the Notice of Discharge having any documentation or assessments for Resident #1. -She notified Resident #1's responsible party by email on 10/15/2021 regarding Resident #1's immediate discharge from the facility. -She was not aware what Resident #1's responsible party had planned for Resident #1's living arrangements on 10/15/2021 after Resident #1 left the facility that morning.	D 229		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to have a therapeutic menu for 1 of 1 sampled residents with a physician's order for a renal diet. (Resident #4). The findings are: Review of Resident #4's current FL2 dated 10/18/21 revealed: -Diagnoses included end stage renal disease (ESRD). -An order for a renal diet. Observations during the initial kitchen tour on	D 296		

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 _____	C 10/26/2021

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 296	Continued From page 5	D 296		

10/19/21 at 4:00pm revealed:
-The menu posted was for residents on a regular diet.
-There was not a menu for a renal diet posted.

Review of the facility's therapeutic diet list dated 10/15/21 revealed:
-Resident #4 was not on the list.
-There were not any residents on the list who were on a renal diet.

Interview with Resident #4 on 10/20/21 at 10:32am revealed:
-The facility did not have her on a special diet but she monitored her own dietary intake due to diagnoses of ESRD and diabetes.
-She did not always follow the dietary restrictions that her dialysis dietitian recommended since she really enjoyed eating banana splits.
-She was served chicken pot pie, a baked sweet potato, peas and carrots for the dinner service meal on 10/19/21 and ate all of her dinner.

Interview with the Dietary Manager (DM) on 10/19/21 at 4:00pm and 4:49pm revealed:
-The therapeutic diet list was up to date.
-The kitchen only had a copy of the regular menu and made small changes to accommodate other therapeutic diets.
-He was not given a renal diet menu when he started 4 months ago and did not receive one recently.

Telephone interview with the corporate dietitian on 10/20/21 at 9:35am revealed:
-When a resident was ordered a renal diet, the facility was expected to restrict potatoes, tomatoes, oranges, orange slices and bananas.
-She expected the facility to have a copy of the Diet Conversion Sheet that explained the diet

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 _____	C 10/26/2021

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

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D 296	Continued From page 6 restrictions of a renal diet but she also emailed a copy to the DM on 10/19/21 in the evening. Telephone interview with the Administrator on 10/25/21 at 2:50pm revealed the DM was expected to request the therapeutic menu from the corporate dietitian, by the next meal, if the information was not in the diet manual.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure therapeutic diets was served as ordered for 1 of 2 sampled residents (Resident # 4) with a renal diet. The findings are: Review of Resident #4's current FL2 dated 10/18/21 revealed: -Diagnoses included end stage renal disease (ESRD). -An order for a renal diet. Review of electronic mail (email) messages between the Resident Care Director (RCD),	D 310		

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 _____	C 10/26/2021

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

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D 310	Continued From page 7	D 310		

Dietary Manager (DM) and Resident #4's dialysis dietitian dated 10/07/21 revealed:
-The dialysis dietitian recommended Resident #3 was served a renal diet (low potassium, low phosphorus and low sodium) with high protein.
-The RCD did not believe that the facility was able to accommodate a renal diet but planned to contact the corporate Dietitian to see what alternative diet the facility could provide to Resident #4.
-The RCD emailed the DM with the dialysis clinic diet recommendations for Resident #3 and asked if the recommendations could be accommodated.
-The DM replied a renal diet could be provided to the resident.

Review of the therapeutic diet list posted in the DM office on 10/19/21 revealed:
-The list was updated on 10/15/21.
-Resident #4 was not on the therapeutic diet list.
-No one on the therapeutic diet list was on a renal diet.

Interview with Resident #4 on 10/20/21 at 10:32am revealed:
-The facility did not have her on a special diet but she monitored her own dietary intake due to her history of diabetes and ESRD.
-Resident #4 did not always follow the dietary advice that her dietitian gave her.
-She was served a small cup of orange juice at the breakfast meal service on 10/18/21 and drank the juice.
-She was served chicken pot pie, a baked sweet potato, peas and carrots for the dinner meal service on 10/19/21 and ate all of her meal.

Interview with the DM on 10/19/21 at 4:00pm revealed:
-The RCD or the Resident Care Coordinator

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 _____	C 10/26/2021

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

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D 310	Continued From page 8	D 310		

(RCC) updated the therapeutic list monthly.
-If there was a new diet order before the therapeutic list was updated the RCD or RCC emailed him to communicate the new diet order.
-The current therapeutic diet list was up to date.

Interview with a cook on 10/19/21 at 4:45pm revealed he has not been asked to prepare a dialysis/renal diet plate for any of the meal services on 10/18/21 or 10/19/21.

Telephone interview with the DM on 10/19/21 at 4:49pm revealed he was not given a renal diet menu when he started 4 months ago and still did not have a renal diet menu.

Interview with RCD on 10/19/21 at 4:54pm revealed she assumed Resident #4 was being served a renal diet since the DM said the kitchen would be able to provide one.

Telephone interview with the DM on 10/19/21 at 5:12pm revealed most residents did not like the options on the renal diet so they were offered food from the regular menu.

Telephone interview with the corporate dietitian on 10/20/21 at 9:35am revealed:
-The facility only offered select diets and the DDS should have referred to the "Diet Conversion Sheet" for guidance when he received the renal diet order.
-The facility should have already had access to the "Diet Conversion Sheet" but she emailed a copy to the DM on 10/19/21 for reference.
-Resident #4 should have received chicken pot pie, peas, carrots and any allowed vegetable in place of the baked sweet potato for the supper meal service on 10/19/21.
-If a resident requested an item that was not

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 _____	C 10/26/2021

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 310	Continued From page 9	D 310		

allowed on their therapeutic diet then the resident should have been educated that the food is not allowed on their diet.
-If the resident continued to request the item after education was provided then they could have it.
-She was not alerted when residents requested food not allowed on their therapeutic diet.

Telephone interview with the dialysis dietitian on 10/20/21 at 10:10am revealed:
-She recommended Resident #4 follow a low phosphorus, low sodium, low potassium and high protein diet.
-She faxed the facility dietary guidelines monthly.
-The facility had not communicated to her that the resident consumed food not allowed on the renal diet.
-She was not aware that the facility's renal diet only restricted potatoes, tomatoes, oranges, orange juice and bananas.

Telephone interview with a representative from Resident #4's Nephrologist's office on 10/20/21 at 11:45am revealed:
-All dialysis patients who were discharged from the hospital were ordered a renal diet.
-Complications which could result in Resident #4 not receiving a renal diet could be; issues with increased blood pressure and cholesterol, and the body's ability to maintain the amount of potassium required for a healthy body.
-A renal diet could also help prevent nausea, vomiting and diarrhea associated with dialysis.

Telephone interview with the Administrator on 10/25/21 at 2:50pm revealed:
-She expected the resident to receive their new therapeutic diet at the following meal after the DM was provided the order.
-DM should have requested the therapeutic menu

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 _____	C 10/26/2021

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 310	Continued From page 10 from the corporate dietitian, by the next meal, if the information was not in the diet manual. -If the new therapeutic diet order came in on the weekend then the kitchen was given 48-72 hours to obtain the new menu.	D 310		
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: Based on record reviews and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #1) related to clopidogrel (a medication used to prevent heart attacks and strokes), losartan (a medication used to treat high blood pressure and to help protect the kidneys from damage due to diabetes), memantine (a medication used to decrease the amount of abnormal activity in the brain), ofloxacin (a medication used to treat eye infections), vitamin D3 (a medication used to treat and prevent bone disorders), and administering two doses of quetiapine (a medication used to treat certain mental/mood conditions) and melatonin (a medication used to treat sleep problems) within 12 hours. The findings are:	D 358		

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 _____	C 10/26/2021

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 358	Continued From page 11	D 358		

Review of Resident #1's current FL2 dated 08/09/21 revealed diagnoses included Alzheimer's disease, dementia, history of falls, gait/mobility abnormalities, glaucoma, diabetes 2, and hypertension.

Review of Resident #1's Resident Register dated 08/12/21 revealed she was admitted to the facility on 08/16/21.

a. Review of Resident #1's current FL2 dated 08/09/21 revealed an order for clopidogrel (a medication used to prevent heart attacks and strokes) 75mg every day.

Review of Resident #1's August 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for clopidogrel 75mg take 1 tablet every day scheduled at 8:30am.
-Clopidogrel 75mg was documented as not administered on 08/21/21, 08/22/21, 08/25/21 and 08/27/21.
-Resident #1 did not receive 4 of 11 doses of clopidogrel.

Telephone interview with the facility's contracted pharmacist on 10/21/21 at 2:00pm revealed:
-On 08/21/21, they received an order for clopidogrel 75mg every day.
-On 08/21/21, clopidogrel 75mg, 25 doses were filled and dispensed to the facility to start on 08/22/21.
-The 25 doses of clopidogrel would last until 09/15/21.
-On 09/10/21, clopidogrel 75mg every day, 30 doses were filled and dispensed to the facility to start on 09/11/21.
-The 30 doses of clopidogrel would last until 10/15/21.

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 _____	C 10/26/2021

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

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D 358	Continued From page 12 b. Review of Resident #1's current FL2 dated 08/09/21 revealed an order for an order for losartan (a medication used to treat high blood pressure and to help protect the kidneys from damage due to diabetes) 25mg every day. Review of Resident #1's August 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for losartan 25mg take 1 tablet every day scheduled at 8:30am. -Losartan 25mg was documented as not administered on 08/21/21, 08/22/21, 08/25/21 and 08/27/21. -Resident #1 did not receive 4 of 11 doses of clopidogrel. Telephone interview with the facility's contracted pharmacist on 10/21/21 at 2:00pm revealed: -On 08/21/21, they received an order for losartan 25mg every day. -On 08/21/21, losartan 25mg, 25 doses were filled and dispensed to the facility to start on 08/22/21. -The 25 doses of losartan would last until 09/15/21. -On 09/10/21, losartan 25mg every day, 30 doses were filled and dispensed to the facility to start on 09/11/21. -The 30 doses of losartan would last until 10/15/21. c. Review of Resident #1's current FL2 dated 08/09/21 revealed an order for an order for memantine (a medication used to decrease the amount of abnormal activity in the brain) 10mg every day. Review of Resident #1's subsequent orders	D 358		

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 _____	C 10/26/2021

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 358	Continued From page 13	D 358		

revealed an order dated 08/30/21 to discontinue memantine 10mg every day.

Review of Resident #1's August 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for memantine 10mg take 1 tablet every day scheduled at 8:30am.
-Memantine 10mg was documented as not administered on 08/21/21, 08/22/21, 08/25/21 and 08/27/21.
-Resident #1 did not receive 4 of 11 doses of memantine.

Telephone interview with the facility's contracted pharmacist on 10/21/21 at 2:00pm revealed:
-On 08/21/21, they received an order for memantine 10mg every day.
-On 08/21/21, memantine 10mg, 25 doses were filled and dispensed to the facility to start on 08/22/21.
-They did not receive an order to discontinue the memantine 10mg on 08/30/21.

d. Review of Resident #1's current FL2 dated 08/09/21 revealed an order for an order for ofloxacin (a medication used to treat eye infections) 0.3% apply to eye daily.

Review of Resident #1's subsequent orders revealed an order dated 09/03/21 to discontinue ofloxacin 0.3% to eye daily.

Review of Resident #1's August 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for ofloxacin 0.3% to both eyes every day scheduled at 8:30am.
-Ofloxacin 0.3% was documented as not administered on 08/21/21, 08/22/21, 08/25/21,

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 _____	C 10/26/2021

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 358	Continued From page 14 08/27/21 and 08/30/21. -Resident #1 did not receive 5 of 10 doses of ofloxacin. Telephone interview with Resident #1's Power of Attorney (POA) on 10/19/21 at 11:00am revealed: -The resident's medications were not being administered as they were prior to admission to the facility, when she lived with the POA. -She did not supply the eye drops upon admission, they were dispensed from the pharmacy. -The primary care physician (PCP) was supposed to discontinue the eye drops prior to admission to the facility. -According to the eMARs the POA received from the facility, the MAs had documented administering the eye drops once daily in both eyes. Interview with the Resident Care Director (RCD) on 10/21/21 at 10:04am revealed: -The resident's power of attorney (POA) informed her prior to admission Resident #1's eye drops should be discontinued, but there was no order. -On 08/13/21, the RCD sent an order clarification for the ofloxacin eye drops to Resident #1's primary care physician (PCP). -The PCP contacted the ophthalmologist who initially prescribed the ofloxacin eye drops and the order was discontinued on 09/03/21. Telephone interview with the facility's contracted pharmacist on 10/21/21 at 2:00pm revealed: -On 08/21/21, they received an order for ofloxacin 0.3%, a 5ml bottle, to eye(s) every day. -On 08/21/21, ofloxacin 0.3% was filled and dispensed to the facility to start on 08/22/21. -On 08/19/21, the pharmacy received an FL2 dated 08/09/21, with a note to the side of the eye	D 358		

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 _____	C 10/26/2021

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 358	Continued From page 15	D 358		

drops, "discontinued by specialist".
-The FL2 dated 08/09/21 received on 08/19/21 was a copy of the FL2 received on 08/21/21 with the note about the eye drops discontinued by the specialist.
-She did not consider that an order and an order was requested by the pharmacy on 08/19/21 from the facility.
-On 09/03/21, an order was faxed to the pharmacy to discontinue the ofloxacin 0.3% at this time signed by an ear, nose and throat physician.

e. Review of Resident #1's current FL2 dated 08/09/21 revealed an order for an order for an order for Vitamin D3 (a medication used to treat and prevent bone disorders) 10mcg, 2 tablets every day.

Review of Resident #1's August 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for vitamin D3 10mcg, take 2 tablets every day scheduled at 8:30am.
-Vitamin D3 was documented as not administered on 08/21/21, 08/22/21, 08/25/21 and 08/27/21.
-Resident #1 did not receive 4 of 11 doses of vitamin D3.

Telephone interview with the facility's contracted pharmacist on 10/21/21 at 2:00pm revealed:
-On 08/21/21, they received an order for vitamin D3 10mcg, 2 tablets every day.
-On 08/21/21, vitamin D3 10mcg, 50 tablets (25 doses) were filled and dispensed to the facility to start on 08/22/21.
-The 25 doses of vitamin D3 would last until 09/15/21.
-On 09/10/21, vitamin D3 10mcg, 2 tablets every

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 _____	C 10/26/2021

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 358	Continued From page 16	D 358		

day, 60 tablets (30 doses) were filled and dispensed to the facility to start on 09/11/21.
-The 30 doses of vitamin D3 would last until 10/15/21.

f. Review of Resident #1's current FL2 dated 08/09/21 revealed an order for quetiapine (a medication used to treat certain mental/mood conditions) 25mg every night.

Review of Resident #1's subsequent orders revealed:
-An order dated 09/08/21 to increase quetiapine to 50mg every night.
-An order dated 10/01/21 to decrease quetiapine to 25mg every day.

Review of Resident #1's August 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for quetiapine 25mg take 1 tablet every night scheduled at 8:00pm, from 08/20/21 to 08/31/21.
-Quetiapine 25mg was documented as not administered on 08/20/21.
-Resident #1 did not receive 1 of 12 doses of quetiapine.

Review of Resident #1's September 2021 eMAR revealed:
-There was an entry for quetiapine 25mg take 1 tablet every day scheduled at 8:00pm.
-Quetiapine 25mg was documented as administered on 09/01/21 to 09/08/21.
-There was an entry for quetiapine 50mg take 1 tablet every day scheduled at 9:30pm.
-Quetiapine 25mg was documented as administered on 09/09/21 to 09/12/21.
-There was an entry for quetiapine 50mg take 1 tablet every day scheduled at 10:00pm.

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 _____	C 10/26/2021

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 358	Continued From page 17 -Quetiapine 50mg was documented as administered on 09/13/21 to 09/16/21 and on 09/18/21 to 09/30/21. -Quetiapine 50mg was documented as not administered on 09/17/21. -Quetiapine 50mg was documented as administered on 09/19/21 at 5:42am and 9:23pm. -Resident #1 received a double dose of quetiapine 50mg on 09/19/21. Telephone interview with the facility's contracted pharmacist on 10/21/21 at 2:00pm revealed: -On 08/21/21, they received an order for quetiapine 25mg every day. -On 08/21/21, quetiapine 25mg, 25 tablets were filled and dispensed to the facility to start on 08/22/21. -The 25 doses of quetiapine would last until 09/15/21. -On 09/10/21, quetiapine 25mg every day, 30 tablets were filled and dispensed to the facility to start on 09/11/21. -The 30 doses of quetiapine 25mg would last until 10/15/21. -On 09/19/21, they received an order for quetiapine 50mg every night and 2 tablets were dispensed from the back up pharmacy to the facility to start on 09/19/21. -On 09/20/21, quetiapine 50mg, 25 tablets were filled and dispensed to the facility to start on 09/21/21. -On 10/02/21, they received an order to quetiapine 25mg every night and 13 tablets were dispensed to the facility to start on 10/03/21. -There should have been 22 doses of quetiapine 25mg and 16 doses of quetiapine 50mg. g. Review of Resident #1's subsequent orders revealed an order dated 08/30/21 for melatonin 3mg every night.	D 358		

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 _____	C 10/26/2021

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 358	Continued From page 18 Review of Resident #1's September 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for melatonin 3mg take 1 tablet every night scheduled at 8:00pm. -Melatonin 3mg was documented as administered on 09/01/21, and on 09/03/21 to 09/08/21. -Melatonin 3mg was documented as not administered on 09/02/21. -There was an entry for melatonin 3mg take 1 tablet every night scheduled at 9:30pm. -Melatonin 3mg was documented as administered from 09/09/21 to 09/12/21. -There was an entry for melatonin 3mg take 1 tablet every night scheduled at 10:00pm. -Melatonin 3mg was documented as administered from 09/13/21 to 09/30/21. -Melatonin 3mg was documented as administered on 09/19/21 at 5:42am and 9:30pm. -Resident #1 did not receive 1 of 30 doses of melatonin 3mg. -Resident #1 received a double dose of melatonin 3mg on 09/19/21. Telephone interview with the facility's contracted pharmacist on 10/21/21 at 2:00pm revealed: -On 08/30/21, they received an order for melatonin 3mg every night. -On 08/30/21, melatonin, 16 tablets were filled and dispensed to the facility to start on 08/30/21. -The 16 doses of melatonin would last until 09/15/21. -On 09/10/21, melatonin, 30 tablets were filled and dispensed to the facility to start on 09/30/21. -The 30 doses of melatonin would last until 10/15/21. Attempted telephone interview with Resident #1's	D 358		

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 _____	C 10/26/2021

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 358	Continued From page 19	D 358		

primary care physician on 10/21/21 at 9:05am was unsuccessful.

Interview with a medication Aide (MA) on 10/21/21 at 10:30am revealed
-Resident #1 left for the day program before the 8:00am medication pass.
-The MAs on third shift gave Resident #1 her medications before she arrived.
-She thought the resident received all the morning medications on third shift.
-She could only see the medications for her shift on the electronic administration record (eMAR) dashboard, and there was no message on the dashboard that Resident #1 had missed her morning medications.
-She never administered medications in the morning to Resident #1.
-Resident #1 had already left the floor for breakfast and the bus when the MA arrived for her shift.

A second interview with the MA on 10/21/21 at 1:36pm revealed:
-She did not administer medications to Resident #1 in the dining room before Resident #1 left for the day program.
-She did know why she documented Resident #1's medications were administered from 08/25/21 through 09/07/21 at 8:30am when Resident #1 was at the Day program.

Interview with the Resident Care Director (RCD) on 10/21/21 at 3:45pm revealed:
-Resident #1 was not admitted with any of her medications.
-Resident #1's medications had to be ordered from the pharmacy on 08/21/21.

Interview with the RCD on 10/22/21 at 9:34am

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 _____	C 10/26/2021

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

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D 358	Continued From page 20 revealed: -The administration of a medication by the MA, despite the time of administration, was reflected in the documentation on the eMAR as given at the scheduled time. -The Resident Care Coordinator (RCC) was responsible for printing a "detail report" of the residents' medication administration, on a weekly basis. -The detail report captured the actual time the medication was documented as administered and was a more accurate picture than the eMAR documentation. -The detail report showed missed medications and medications not administered within the time frame that was entered on the eMAR. -The RCC was responsible for taking care of any exceptions from the detailed report with the staff. -She did not run a detail report or correct exceptions from the detail report. -Her expectation was for the MAs to administer the medications per the physician's order, and in the time frame that was entered on the eMAR. -If a resident was out of the building during the medication administration pass, the MAs should document on the eMAR "LOA" (leave of absence) and administer the daily medication when the resident returned. -The MA should document in the progress notes when the medication was actually administered. -If the missed medication was given more than once a day, the MAs should call and notify her, and she would instruct the MA on what to do next or send a message to the resident's PCP for direction. -She did not know Resident #1 had missed the clopidogrel, losartan, memantine, ofloxacin, vitamin D3, melatonin, and quetiapine and the staff had not administered the missed morning medications when she returned to the facility.	D 358		

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 _____	C 10/26/2021

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 358	Continued From page 21 -She was informed the MA was administering Resident #1's morning medications in the dining room before she left on the bus for the Day program. -When she was made aware the time entered for Resident #1's medication administration was not compatible with her Day program schedule, she changed the administration time from 8:00am to 6:30am on 09/07/21. Interview with the Administrator on 10/25/21 at 2:55pm revealed: -The regional Health and Wellness Director (HWD) a Registered nurse (RN), assisted the clinical team with clinical guidance and use of the eMAR system. -An order would be given to the RCD or the Special Care Unit (SCU) Resident Care Coordinator (RCC), depending if the order was for an Assisted Living (AL) resident or a SCU resident. -The order would be placed in their respective mail folders in the conference room. -The RCD, the RCC or the lead MA could enter orders onto the eMAR. -She did not know if the RCD or the AL RCC reviewed the orders once on the eMAR. -The RCC was responsible for printing and reviewing the detail reports from the software program which included missed medications, medications not administered on time and medications as needed (prn's), and the times administered. -She did not know how often the AL RCC ran those reports, but it should be at least weekly.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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 _____	C 10/26/2021

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 367	Continued From page 22 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the electronic medication administration record (eMAR) for 1 of 5 sampled residents related to administering clopidogrel, losartan, memantine, and vitamin D3 and documentation at a different time, (Resident #1) and documentation the administration of llevro eye drops when the llevro was not in the building (Resident #1). The findings are: Review of Resident #1's current FL2 dated 08/09/21 revealed: -Diagnoses included Alzheimer's disease,	D 367		

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 _____	C 10/26/2021

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 367	Continued From page 23	D 367		

dementia, history of falls, gait/mobility abnormalities, glaucoma, diabetes 2, and hypertension.
-An order for clopidogrel (a medication used to prevent heart attacks and strokes) 75mg every day.
-An order for losartan (a medication used to treat high blood pressure and to help protect the kidneys from damage due to diabetes) 25mg every day.
-An order for memantine (a medication used to decrease the amount of abnormal activity in the brain) 10mg every day.
-An order for Vitamin D3 (a medication used to treat and prevent bone disorders) 10mcg, 2 tablets every day.
-An order for Nepafenac (Ilevro, a medication used to treat eye pain, irritation and pain after cataract surgery) 0.3% to eye every day.

Review of Resident #1's Resident Register dated 08/12/21 revealed she was admitted to the facility on 08/16/21.

Review of Resident #1's Clinical Notes Report revealed she was admitted to the facility on 08/20/21 at 1:00pm.

Review of Resident #1's record revealed Resident #1 was given a Notice of Transfer/Discharge on 10/15/21.

Review of Resident #1's pharmacy receipt dated 09/16/21 revealed:
-Clopidogrel 75mg, 25 doses, losartan 25mg, 25 doses, memantine 10mg, 25 doses, and vitamin D3 10mcg, 50 tablets (25 doses) were filled and delivered to the facility on 08/21/21.
-The Ilevro 0.3% eye drops were never filled or dispensed to the facility.

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 _____	C 10/26/2021

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 367	Continued From page 24 a. Review of Resident #1's August 2021 electronic Medication Record (eMAR) revealed: -There was an entry dated 08/21/21 to 08/30/21 for clopidogrel 75mg, losartan 25mg, memantine 10mg, and vitamin D3 10mcg scheduled to be administered every day at 8:30am, -A late entry for clopidogrel documented on 09/14/21 at 3:08pm as "medications were administered" on 08/24/21, 08/26/21, 08/31/21 "before Resident #1 left the building". -A late entry for clopidogrel documented on 09/15/21 at 12:19pm as "medications were administered" on 08/24/21 "before Resident #1 left the building". -A late entry for losartan documented on 09/14/21 at 3:23pm, as "medications were administered" on 08/26/21, 08/30/21 and 08/31/21 "before Resident #1 left the building". -A late entry for losartan documented on 09/15/21 at 12:21pm, as "medications were administered" on 08/26/21, 08/30/21 and 08/31/21 "before Resident #1 left the building". -A late entry for, memantine documented on 09/15/21 at 12:22pm and 12:25pm, as "medications were administered" on 08/24/21 and 08/26/21 "before Resident #1 left the building". -A late entry for vitamin D3 documented on 09/15/21 at 12:27pm, as "medications were administered" on 08/26/21 "before Resident #1 left the building". Review of Resident #1's August 2021 electronic Medication Record (eMAR) revealed: -There was an entry dated 09/01/21 to 09/30/21 for clopidogrel 75mg, losartan 25mg scheduled to be administered every day at 8:30am. -A late entry for clopidogrel documented on 09/14/21 at 3:11pm, 3:12pm, 3:28pm and 3:29pm as "medications were administered" on 09/01/21	D 367		

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 _____	C 10/26/2021

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 367	Continued From page 25	D 367		

and 09/02/21 "before Resident #1 left the building".

b. Review of Resident #1's August 2021 eMAR revealed:
-There was an entry dated 08/21/21 to 08/31/21 for Ilevro 0.3% to eye every day, scheduled to be administered at 8:30am.
-A late entry for Ilevro documented on 09/14/21 at 3:13pm and 3:17pm, as "signing error medication was administered" on 08/26/21 and 08/31/21.

Telephone interview with the facility's contracted pharmacist on 10/21/21 at 12:38pm revealed:
-Ilevro eye drops were not sent to the facility due to being denied by insurance.
-The order for Ilevro was discontinued on 09/03/21.

Interview with the Regional Health and Wellness Director (HWD) Registered nurse (RN) on 10/22/21 at 8:35am revealed:
-The MAs should be documenting administration of medications immediately after their administration.
-The Resident Care Director (RCD) entered the medication administration time as 8:30am when Resident #1 first arrived and was not attending the adult day program.
-When Resident #1 started to attend the day program on 08/25/21, the time of medication administration was changed to 6:30am.
-The MA should have documented the medication was not administered at 8:30am due to a leave of absence (LOA).
-Then the MA should have administered the medication when she returned and put a note in the eMAR progress notes documenting the administration time.

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 _____	C 10/26/2021

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 367	Continued From page 26 Interview with the Administrator on 10/25/21 at 2:55pm -The regional HWD assisted the clinical team with guidance and the use of the eMAR system. -If a resident was out of the facility and did not receive their medications in the time entered on the eMAR, the medication should be documented as not given and a note entered stating the resident was "LOA". -If the medication was administered once daily, the MA could administer the medication when the resident returned and document in the e-progress note the time the medication was administered. -She expected the MAs to follow the policy and document a resident was out of the building (LOA), and administer the medications when the resident returned, documenting that time in the e-Progress notes.	D 367		