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 06/24/2022

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 complaint investigation on 06/21/22- 06/24/22. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 06/15/22.	D 000		
D 049	10A NCAC 13F .0305 (d) Physical Environment 10A NCAC 13F .0305Physical Environment (d) The requirements for the bedroom are: (1) The number of resident beds set up shall not exceed the licensed capacity of the facility; (2) There shall be bedrooms sufficient in number and size to meet the individual needs according to age and sex of the residents, any live-in staff and other persons living in the home. Residents shall not share bedrooms with staff or other live-in non-residents; (3) Only rooms authorized as bedrooms shall be used for residents' bedrooms; (4) Bedrooms shall be located on an outside wall and off a corridor. A room where access is through a bathroom, kitchen, or another bedroom shall not be approved for a resident's bedroom; (5) There shall be a minimum area of 100 square feet excluding vestibule, closet or wardrobe space in rooms occupied by one person and a minimum area of 80 square feet per bed, excluding vestibule, closet or wardrobe space, in rooms occupied by two people; (6) The total number of residents assigned to a bedroom shall not exceed the number authorized for that particular bedroom; (7) A bedroom may not be occupied by more than two residents. (8) Resident bedrooms shall be designed to accommodate all required furnishings; (9) Each resident bedroom shall be ventilated	D 049		

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 06/24/2022

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 049	Continued From page 1	D 049		

with one or more windows which are maintained operable and well lighted. The window area shall be equivalent to at least eight percent of the floor space and be provided with insect screens. The window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide. The windows shall be low enough to see outdoors from the bed and chair, with a maximum 36 inch sill height; and
(10) Bedroom closets or wardrobes shall be large enough to provide each resident with a minimum of 48 cubic feet of clothing storage space (approximately two feet deep by three feet wide by eight feet high) of which at least one-half shall be for hanging clothes with an adjustable height hanging bar.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations and interviews the facility failed to restrict a window opening to six-inches for a resident with history of attempted suicide with access to unrestricted 3rd floor window (Resident #1).

The findings are:

Review of Resident #1's most current FL2 dated 02/17/22 revealed:
-Resident #1's level of care was assisted living.
-The resident was discharged from the hospital back to the assisted living facility.
-Diagnoses included major depressive disorder.

Review of Resident #1's hospital notes from 01/31/21 to 02/07/22 revealed:
-She was sent to the hospital because she asked facility staff "How do I kill myself?".
-She had suicidal ideations and worsening

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 06/24/2022

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 049	Continued From page 2	D 049		

anxiety and depression over the past year.
-She was thinking of different ways to kill herself but was unsure how to get access in the facility.
-Resident #1 was to be involuntarily committed (IVC) because her suicidality (the risk of suicide, indicated by intent and a suicidal plan) was concerning and she may leave and be an imminent risk to herself.
-Resident #1 told hospital staff "killing myself is the best thing to do" and asked the staff member to kill her.
-She stated that if she did not get help, she would kill herself.
-She was discharged to inpatient psychiatry on 02/07/22.

Review of Resident #1's accident/incident report dated 06/15/22 revealed:
-A staff member was asked to search the building for Resident #1.
-Resident #1 could not be found so a medication aide (MA) unlocked her room and saw that a window was open.
-The staff member looked out the window and saw Resident #1 face down on the grass.
-The local law enforcement and 911 were called.

Observation of room #320 on 06/21/22 at 4:10pm revealed:
-Resident #1 had resided in room #320.
-The window from which Resident #1 fell was not able to be viewed from the door to the room.
-The window was one of the newer vinyl windows the Maintenance Director had described.
-The window was closed, and the child safety tabs were engaged.
-The screen was in the lowered position with an "L" shaped tear approximately one and half inches in from the left side of the frame and along the bottom edge of the frame.

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 06/24/2022

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 049	Continued From page 3	D 049		

-There was approximately three inches at the upper left part of the screen frame where the screen was bowed out and no longer in the frame, and the spline was displaced along this area.

Interview with the Maintenance Director on 06/21/22 at 3:30pm revealed:
-The facility had two types of windows, older wooden ones and newer vinyl ones.
-The newer windows were easier to open than the older ones.
-Resident #1's room was a corner unit and had windows on two walls.
-One wall had the new windows and the other wall had the older wooden windows.
-The new windows were equipped with safety restricting tabs that limited the height the window could open to 6 inches.
-These tabs were easy to engage and disengage by just pressing on them.
-The screens in the new windows were half screens and easy to slide up and down.
-He thought Resident #1 was able to make small hole in the screen on the lower left corner and then tear the screen upward and toward the right, making a "L" shaped tear.
-He thought once a small hole was made, the screen would be easy to tear.
-In the Special Care Unit (SCU), there were bolts or screws placed in the windows to limit the height the window could be opened.
-He had not been asked to modify any windows to restrict opening in Resident #1's room since he started working at the facility, approximately fourteen months ago.

Interview with a law enforcement officer on 06/22/22 at 1:53pm and 4:24pm revealed:
-He was called to the scene because a 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 06/24/2022

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 049	Continued From page 4	D 049		

had fallen out of a window at the facility.
-When he arrived, Resident #1 was on the ground, covered with a sheet and had been pronounced dead.
-The resident's window was closed, and he looked up from where the resident laid on the ground to her window on the third floor and the left screen was about halfway up with a "L" shaped tear in the screen.
-He was told the Administrator had told staff to close the window before he arrived.
-He was told the windows could only open six inches, but he was able to open the window and the screen all the way open.
-He said his team was thinking the resident tried to go out the tear in the screen and realized she could not do it and then pushed the screen up because the screen was almost halfway open when he arrived after the resident was found on the ground below.

Interview with the Administrator on 06/24/22 at 2:59pm revealed:
-If she thought Resident #1 was planning to harm herself, she would have moved her down to the first floor.
-She thought the child proof latches installed on the windows were enough for restricting the window opening.

[Refer to tag 0338, 10A NCAC 13F 0909 Resident Rights (Type A1 Violation)]

_____

The facility failed to ensure window access was restricted to six inches in the room of Resident #1, who had a history of suicide attempt with worsening depression and anxiety. This failure resulted in Resident #1 falling out of the window which resulted in serious neglect and constitutes a Type A1 Violation.

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 06/24/2022

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 049	Continued From page 5 The facility provided a Plan of Protection in accordance with G.S. 131D-34 on June 24, 2022 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JULY 24, 2022.	D 049		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) had a criminal background check completed upon hire. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired 10/04/21 as a Medication Aide (MA). -There was no consent for a criminal background check. -There was no documentation for a criminal background check performed. Interview with Staff A on 06/24/22 at 5:15pm revealed: -She was hired in October 2021 as a MA. -She administered medications to residents. -She did not know if a criminal background check had been completed on her.	D 139		

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 06/24/2022

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 139	Continued From page 6 Telephone interview with the Business Office Manager (BOM) on 06/24/22 at 5:36pm revealed: -She began working at the facility about two and a half months ago. -She was responsible for ensuring criminal background checks were completed for new hires. -She had just completed her training and had not had a chance to audit the personnel records yet. Interview with the Administrator on 06/24/22 at 6:00pm revealed: -The BOM was responsible for making sure all criminal background checks were completed on all new hires. -The BOM was responsible for auditing the personnel records monthly by picking a sample of ten of them. -The corporate office did quarterly audits of personnel records. -She expected all staff, when hired, to have a criminal background check completed.	D 139		
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: TYPE A1 VIOLATION Based on interviews, observations and record reviews the facility failed to ensure residents were free from neglect for 1 of 7 sampled residents who expressed suicidal ideations with history of	D 338		

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 06/24/2022

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 338	Continued From page 7	D 338		

suicide attempts and hospitalizations resulting in the resident falling from a third story window (Resident #1).

The findings are:

Review of Resident #1's FL2 dated 08/27/21 revealed:
-Diagnoses included depression.
-An order for duloxetine 20 mg (a medication used to treat depression and anxiety) twice a day.
-An order for escitalopram 20 mg (a medication used to treat depression) daily.
-An order for hydroxyzine 25 mg (a medication used to treat anxiety) twice a day.
-An order for mirtazapine 15 mg (a medication used to treat depression) daily.

Review of Resident #1's Resident Register revealed her date of admission was 08/31/21.

Review of Resident #1's hospital notes from 08/10/21 to 08/28/21 revealed:
-Resident #1 was admitted to the hospital from home due to COVID-19 and suicidal ideation on 08/10/21, prior to her admission to the facility.
-Resident #1's anxiety and depression had been ongoing over a year.
-She did not have a plan to commit suicide but had attempted suicide in the past.
-She was seen by psychiatry on 08/17/21 and had plans for a behavioral health hospitalization but her diagnosis of COVID-19 complicated the plans of going to behavioral health.
-Psychiatry recommended increasing duloxetine to 90 mg daily, continuing mirtazapine and utilizing hydroxyzine first for anxiety.
-Her COVID-19 test was positive on 08/19/21 and she was unable to be placed at a behavioral health facility until she had two negative

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 06/24/2022

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 338	Continued From page 8	D 338		

COVID-19 tests.
-Resident #1 tested positive again for COVID-19 on 08/25/21.
-On 08/26/22, the psychiatric team had a discussion with Resident #1's family and the family thought she would be better at home outside of the hospital setting.
-Psychiatry no longer thought Resident #1 needed to be transferred to an inpatient psychiatry facility, and her family was not able to take her home.
-Resident #1 was discharged to the facility on 08/31/21.

Review of Resident #1's facility Clinical Notes Report dated 09/12/21 revealed Resident #1 was sent to the hospital due to chest pain.

Resident #1's hospital notes from 09/12/21 to 09/14/21 were requested but were not available prior to exit on 06/24/22.

Review of Resident #1's FL2 dated 09/14/21 revealed:
-Diagnoses included major depressive disorder (MDD) and history of suicidal ideation.
-An order for duloxetine DR 60 mg daily.
-An order for mirtazapine 15 mg before bed.
-An order for trazadone 50 mg (a medication used to treat depression), half tablet before bed.

Review of Resident #1's facility Clinical Notes Report dated 09/19/21 revealed:
-At 1:55pm, Resident #1 was feeling nervous and anxious and asked for medication to calm her nerves.
-She did not have any as needed medication for anxiety ordered so the staff member notified the second shift medication aide (MA) to continue to check on her throughout the evening.

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 06/24/2022

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 338	Continued From page 9 Review of Resident #1's Psychiatrist's progress note dated 09/20/21 revealed: -Resident #1's first encounter was on 09/20/21. -Her assessment included cognitive impairment, recurrent depression, insomnia, and anxiety disorder. -Resident #1 scored seven on a Brief Interview for Mental Status (BIMS) test which indicated severe cognitive impairment; however, family insisted that she was not cognitively impaired or had a history of dementia. -Her family stated that she had a history of depression and her hospital notes revealed verbalization of suicidal thoughts in April 2021 and August 2021. -Resident #1 denied suicidal and homicidal ideations at the time of the visit. -Her family member endorsed that Resident #1 wanted to kill herself several years ago. -There were orders to discontinue duloxetine, trazadone at its current dose and mirtazapine. -An order for lorazepam (a medication used to treat anxiety) 0.5 mg twice a day for 14 days for anxiety. -An order for trazadone 50 mg, half tablet at bedtime for insomnia. -An order for escitalopram 10 mg daily for depression and anxiety. Review of Resident #1's Psychiatrist's progress note dated 10/04/21 revealed: -A different provider had taken over her care. -She felt much better after starting escitalopram but continued to have some anxiety and seemed anxious at the visit. -Resident #1 was prescribed lorazepam 0.5 mg twice daily a couple of weeks ago and her family stated that she did well on lorazepam 1 mg twice daily previously.	D 338		

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 06/24/2022

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 338	Continued From page 10	D 338		

-An order to discontinue lorazepam 0.5 mg twice daily and to start lorazepam 1 mg twice daily for anxiety.

Telephone interview with Resident #1's Psychiatrist on 06/22/22 at 11:12am revealed:
-She started seeing Resident #1 around the end of September 2021.
-Resident #1 was anxious due to being new to the facility and she had a history of anxiety.
-Resident #1 also had a history of depression but mainly wanted to discuss her anxiety during their visits.
-She never felt that Resident #1 was unsafe at the assisted living facility.
-She only prescribed medication for Resident #1's anxiety and depression and did not provide the facility with any other interventions.

Review of Resident #1's emergency department (ED) note dated 10/18/21 revealed:
-She was seen for abdominal pain, vomiting, and diarrhea.
-An order for ondansetron ODT(orally disintegrating tablet) (used to treat nausea and vomiting) 4 mg three times a day for three days.

Review of Resident #1's facility Clinical Notes Report dated 10/24/21 revealed Resident #1 requested a stronger medication than lorazepam from staff.

Review of Resident #1's Psychiatrist's progress note dated 11/01/21 revealed:
-Resident #1 reported depression and denied suicidal thoughts.
-An order to increase trazadone to 50 mg before bedtime for sleep and mood support.

Review of Resident #1's Psychotherapist's note

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 06/24/2022

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 338	Continued From page 11	D 338		

dated 11/16/21 revealed:
-The reason for the referral included: stress of living situation, worries, anxiety, sadness, and hallucinations.
-Resident #1's symptoms for that visit included anxiety and irritability.
-She was currently not a danger to herself or others at the time of the visit.
-Her prognosis was fair and she did not have any barriers to treatment.
-A summary of the session was not included in the documentation.

Telephone interview with Resident #1's Psychotherapist on 06/22/22 at 11:41am revealed:
-She started seeing Resident #1 bi-weekly in November 2021.
-She spoke with Resident #1's family and they informed her that Resident #1 had history of anxiety, depression, and attention seeking behavior.
-Her visits typically consisted of meeting in Resident #1's room, discussing any changes in her moods, her current symptoms, family history, and encouraging healthy coping skills or strategies for anxiety and depression.
-The healthy coping skills mainly consisted of recommending participation in facility planned activities for a distraction from her feelings of anxiety and depression.
-She sometimes updated the previous Resident Care Director (RCD) on Resident #1's participation in their visit but did not discuss interventions, such as healthy coping skills, that the staff at the facility could provide to Resident #1.

Resident #1's Psychiatrist's note dated 11/29/21 was requested but was not available for review

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 06/24/2022

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 338	Continued From page 12	D 338		

prior to exit on 06/24/22.

Review of Resident #1's Psychotherapist's note dated 11/30/21 revealed:
-Resident #1's symptoms for that visit included anxiety and irritability.
-She currently was not a danger to herself or others at the time of visit.
-Her prognosis was fair and she did not have any barriers to treatment.
-A summary of the session was not included in the documentation.

Review of Resident #1's facility Clinical Notes Report dated 12/04/21 revealed:
-An as needed medication was given to Resident #1 due to nausea.
-She had a crying episode and the MA walked her back to room and assured her everything would be fine.
-Staff would monitor Resident #1 for changes.
-There was no documentation the Resident Care Coordinator (RCC) or the RCD was notified.
-There was no documentation that staff increased frequent checks on the resident.

Resident #1's Psychiatrist's note dated 12/13/21 was requested but was not available for review prior to exit on 06/24/22.

Review of Resident #1's hospital notes dated 12/20/21 revealed:
-Resident #1 was sent to the hospital with three days of anxiety, abdominal pain, chest pain and shortness of breath.
-She reported feeling nervous for the last five days with 12/19/21 and 12/20/21 being particularly bad. She "can't breathe, is too nervous".
-Behavioral Health was consulted on 12/21/21

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 06/24/2022

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 338	Continued From page 13	D 338		

and documented Resident #1 was not at an acutely elevated mental health risk with no acute dangerousness noted, reported or observed.
-She had acute chronic anxiety and reported worsening anxiety when her medications were changed by her mental health provider.
-Resident #1 thought mirtazapine worked well for her and the doctor thought it would be a better fit than escitalopram to treat her insomnia, low appetite and abdominal distress.
-The Behavioral Health doctor's plan for Resident #1 was to discharge her back to the facility, decrease her escitalopram to 10 mg daily, restart mirtazapine 7.5 mg for one week then increase to 15 mg before bedtime, recommended avoiding benzodiazepines and only use lorazepam on an as needed basis.
-On 12/21/21 she was discharged back to the facility.

Review of Resident #1's FL2 dated 12/21/21 revealed:
-Diagnoses included shortness of breath.
-Under the medications section "see D/C (discharge) instructions" was documented.
-The discharge instructions included orders for escitalopram 20 mg daily, lorazepam 0.5 mg three times per day, melatonin (a supplement used to help induce sleep) 3 mg, two tablets before bedtime as needed, escitalopram 10 mg daily, mirtazapine 7.5 mg one week then increase to 15 mg before bedtime.

Resident #1's Psychiatrist's note dated 12/27/21 was requested but was not available for review prior to exit on 06/24/22.

Review of Resident #1's facility Clinical Notes Report dated 12/31/21 revealed:
-Resident #1 told the Activity Director she took 25

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 06/24/2022

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 338	Continued From page 14	D 338		

pills and no longer wanted to live.
-The Memory Care Coordinator (MCC) was called to talk to Resident #1 and determined that she took acetaminophen.
-Resident #1 stated "she couldn't do it anymore and she needed help. We [the facility] could no longer help her".
-The MCC called the nurse and was advised to call 911.
-Resident #1 told the police that she needed the right people to help and could not sleep, had a headache, her stomach hurt and then she cried.
-The medics arrived and took her to the hospital.

Review of Resident #1's hospital discharge summary dated 01/04/21 revealed:
-Resident #1 came to the ED after reporting she took "20" acetaminophen for pain and endorsed suicidal ideation to ED staff.
-Intravenous fluids were given and poison control was contacted but they did not make any recommendations related to her acetaminophen ingestion.
-Her acetaminophen level was 9.3 mcg/mL with 10-20 mcg/mL considered a safe level of acetaminophen.
-Resident #1 was admitted to the hospital for monitoring and was seen by psychiatry.
-Psychiatry recommended starting mirtazapine and hydroxyzine and discontinue trazadone.
-On 01/04/22, she was cleared by psychiatry to be discharged back to the facility, and follow up with an outpatient psychiatrist.

Review of Resident #1's FL2 dated 01/04/22 revealed:
-Diagnoses included Tylenol overdose (OD), suicidal ideation, and MDD.
-A nursing facility was documented as her recommended level of care.

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 06/24/2022

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 338	Continued From page 15	D 338		

-Under the medications section "See D/C instructions" was documented.
-The discharge instructions had orders to stop escitalopram 20 mg, lorazepam 0.5 mg and trazadone 50 mg.
-The discharge instructions had orders for mirtazapine 15 mg daily and hydroxyzine 25 mg every 6 hours as needed for anxiety.

Resident #1's Psychiatrist's note dated 01/24/22 was requested but it was not available for review prior to exit on 06/24/22.

Interview with the Activity Director (AD) on 06/24/22 at 10:27am revealed:
-Resident #1 came up to her on 12/31/21 and told her that she had taken a handful of acetaminophen "since that was all she had" and stated "I am done".
-She reported the incident to the MCC and the previous RCD.

Interview with the MCC on 06/24/22 at 11:57am revealed:
-On 12/31/21 the AD informed her that Resident #1 had taken multiple pills.
-She searched Resident #1's drawers, cabinets, and closet and did not find any evidence of pills in her possession.
-Resident #1 informed her that she did not take multiple pills and did not know why she made that statement.
-The RCD told her to call 911.
-She did not document the search of Resident #1's room or that Resident #1 told her she did not actually swallow the pills.

Interview with the Administrator on 06/24/22 at 10:00am revealed:
-She was aware Resident #1 was sent to the ED

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 06/24/2022

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 338	Continued From page 16	D 338		

for attempted suicide on 12/31/21.
-She was under the impression that Resident #1 only talked about taking 20 pills and did not think it was true since there was no mention of pumping her stomach at the hospital.
-She did not know that "Tylenol OD" was on Resident #1's FL2 and hospital discharge paperwork dated 01/04/22.
-An investigation was not completed for this event.
-When Resident #1 returned from the hospital, staff were expected to check on her every hour while she was awake for a minimum of three days.

Telephone interview with Resident #1's Psychiatrist on 06/22/22 at 11:12am, and 06/24/22 at 9:03am revealed:
-She typically saw Resident #1 on a monthly basis but may see her less if she was stable.
-Resident #1 had a couple of hospital admissions or ED visits due to changes in her mood and would request hospitalization to possibly get certain medications.
-Her colleague prescribed lorazepam for Resident #1 in September 2021, but she did not like to prescribe lorazepam or alprazolam (a medication used to treat anxiety) since they could be habit forming drugs.
-Resident #1 requested alprazolam but she would not prescribe it to her.
-During one of her hospitalizations, Resident #1's lorazepam was discontinued and she did not restart the medication.
-She had difficulty accessing her records of communication from the facility and did not know if she was notified each time Resident #1 was hospitalized related to her mental health.
-She would follow up with Resident #1 on her regularly scheduled visits and did not plan

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 06/24/2022

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 338	Continued From page 17	D 338		

specific visits to assess Resident #1 after her hospitalizations.
-When she saw Resident #1 after a hospitalization, she did not make any changes to the medications that were started in the hospital.
-She did not instruct staff to put any additional interventions in place after Resident #1 returned from the hospital.

Review of Resident #1's Psychotherapist's note dated 01/25/22 revealed:
-Resident #1's symptoms for that visit included agitation and avoidance.
-She currently was not a danger to herself or others at the time of the visit.
-Her prognosis was fair and she did not have any barriers to treatment.
-A summary of the session was not included in the documentation.

Review of Resident #1's hospital notes dated 01/31/21 revealed:
-She was sent to the hospital because she asked facility staff "How do I kill myself?".
-She had suicidal ideations and worsening anxiety and depression over the past year.
-She was thinking of different ways to kill herself but was unsure how to get access in the facility.
-Resident #1 was to be involuntarily committed (IVC) because her suicidality was concerning and she may leave and be an imminent risk to herself.
-Resident #1 told hospital staff "killing myself is the best thing to do" and asked the staff member to kill her.
-She stated that if she did not get help, she would kill herself.
-Other recommendations besides IVC included a one-on-one sitter for the resident.
-Her IVC ended on 02/07/22 and she was discharged to inpatient psychiatry that day.

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 06/24/2022

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 338	Continued From page 18 Review of Resident #1's inpatient psychiatry notes revealed: -On 02/14/22, she was very depressed, withdrawn to her room, and reported feeling hopeless regarding her housing situation. -On 02/18/22, Resident #1 continued to have intrusive thoughts that she was not good enough. -On 02/18/22, another note revealed she complained she was depressed and needed more medication for anxiety and depression. -On 02/20/22, she was anxious, asked for more medications, complained of being sick, and stated staff were not helping her. Review of Resident #1's current FL2 dated 02/17/22 revealed: -Diagnoses included MDD. -An order for aripiprazole (a medication used to treat mental/mood disorders) 2 mg in the morning. -An order for clonazepam (a medication used to treat anxiety) 0.25 mg once daily, as needed. Resident #1's Psychiatrist's notes dated 03/07/22 to 04/18/22 were requested but were not available for review prior to exit on 06/24/22. Telephone interview with Resident #1's Psychiatrist on 06/22/22 at 11:12am revealed: -Since Resident #1 returned from the behavioral health hospital in February 2022, the facility had not communicated any mood changes so she thought her anxiety and depression had been more stable. -She tried to discuss the cause of her anxiety but Resident #1 would tell her she did not know what caused her anxiety. -She found it difficult to get information from the resident but knew that the psychotherapist would	D 338		

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 06/24/2022

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 338	Continued From page 19	D 338		

be meeting with her twice a month and having in-depth conversations.
-She did not instruct staff to put any additional interventions in place after Resident #1 returned from the behavioral health hospital.

Review of Resident #1's Psychotherapist's note dated 03/08/22 revealed:
-Resident #1's symptoms for that visit included anxiety and worry.
-She was currently not a danger to herself or others at the time of the visit.
-Her prognosis was fair and she did not have any barriers to treatment.
-She did not believe being in a facility was the trigger for her mood change since she did not like being at the hospital either.
-She had been engaging more in the facility and no longer believed others did not like her without cause.

Review of Resident #1's Psychotherapist's note dated 03/22/22 revealed:
-Resident #1's symptoms for that visit included agitation and impulsivity.
-She was currently not a danger to herself or others at the time of the visit.
-Her prognosis was fair and she did not have any barriers to treatment.
-Resident #1 reported she was doing well and engaging in the facility's activities such as a cooking class.

Review of Resident #1's Psychotherapist's note dated 04/05/22 revealed:
-Resident #1 was brief and appeared to be more dismissive.
-She was currently not a danger to herself or others at the time of the visit.
-Her prognosis was fair and she did not have any

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 06/24/2022

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 338	Continued From page 20	D 338		

barriers to treatment.
-She made slight progress that visit.
-She reported feeling "fine" with a decrease in anxiety and symptoms of depression.
-She continued to participate in activities held at the facility.

Telephone interview with Resident #1's Psychotherapist on 06/22/22 at 11:41am revealed:
-Resident #1 reported anxiety related to health and anxiety concerns with stomach aches and nausea.
-She discussed challenges with her family relationships that occurred after they sent her to live at the facility.

Review of Resident #1's Psychiatrist's note dated 04/18/22 revealed:
-Resident #1's moods appeared to be stable and staff did not have any concerns at the time.
-She had been prescribed clonazepam for anxiety and was tolerating the medication well.
-No medication changes were made at this visit.

Review of Resident #1's Psychotherapist's note dated 04/19/22 revealed:
-Resident #1 reported being depressed, anxious and shaking since yesterday (04/18/22).
-She was currently not a danger to herself or others at the time of the visit.
-She typically felt depressed and anxious but being anxious normally overpowered her depression.
-She appeared to be agitated when distraction techniques were attempted and her main concern was her medication.

Review of Resident #1's Care Plan dated 04/20/22 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 06/24/2022

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 338	Continued From page 21	D 338		

-Suicidal was checked in the mental health and social history section.
-"High anxiety at times" was documented under comments.
-Resident #1 was independent with all activities of daily living (ADLs).
-The assessment was completed by the previous RCD and was not signed by the Primary Care Provider (PCP).

Review of Resident #1's Psychiatrist's note dated 05/13/22 revealed:
-Resident #1's moods appeared to be stable and staff did not have any concerns about her mood at that time.
-She was asked to report any worsening symptoms of depression or thoughts of harming self or others.
-She reported an increase in anxiety and was taking clonazepam daily even though it was prescribed as needed for anxiety.
-An order for clonazepam ODT (oral disintegrating tablet) 0.25 mg twice daily.

Review of Resident #1's Psychotherapist's note dated 05/17/22 revealed:
-Resident #1 appeared to be nervous and displaying avoidance.
-She was currently not a danger to herself or others at the time of this visit.
-She had been experiencing feelings of depression but denied suicidal ideation.
-Her stomach pains had been a barrier to her participating in group activities and she was less likely to engage in individual activities to decrease symptoms of depression.
-Resident #1 was not receptive to discussing helpful techniques.
-Her prognosis was fair but motivation was a barrier to treatment for this visit.

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 06/24/2022

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 338	Continued From page 22 Review of Resident #1's facility Clinical Notes Report dated 05/27/22 revealed: -Resident #1 told a MA that she was depressed. -The MA documented that she told Resident #1 to ask her family to make an appointment with a physician to get help. -There was no documentation that the RCC or RCD were notified of Resident #1's comment. Interview with a second MA on 06/21/22 at 11:15am revealed: -She did not know Resident #1 was depressed. -She came out of her room more after her last hospitalization and went to more activities. -Her one close friend who lived down the hall from her moved away about 2 months ago and this made her sad. -She did not have any training working with depressed or suicidal residents at the facility since she started working there. -She knew she would have to watch them more closely, but she was not told to watch this resident. Review of Resident #1's Psychotherapist's note dated 05/31/22 revealed: -Resident #1 was anxious and agitated. -She was currently not a danger to herself or others at the time of the visit. -She was not doing well due to experiencing diarrhea and vomiting several times in the last week. -She was not interested in discussing healthy coping skills and only wanted to discuss her stomach issues. -Her gastrointestinal distress had been interfering with her sleep as well as her ability to relax. -Psychotherapist encouraged Resident #1 to inform facility staff of her stomach issues.	D 338		

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 06/24/2022

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 338	Continued From page 23	D 338		

-Her prognosis was fair but motivation was a barrier to treatment for this visit.

Telephone interview with Resident #1's Psychotherapist on 06/22/22 at 11:41am revealed:
-Resident #1 found participating in the facility's activities helpful to decrease feelings of anxiety and depression some of the time.
-She did not go to activities regularly and seemed to stop going completely by 05/17/22.
-This did not alarm the psychotherapist since it was not a significant change from her past refusals to participate in activities.
-She did not relay this information to any of Resident #1's other providers since they all had access to her notes.
-Resident #1 frequently requested for staff to sit with her in her room.

Review of Resident #1's Psychotherapist's note dated 06/07/22 revealed:
-Resident #1 was irritable and worried during visit.
-She was currently not a danger to herself or others at the time of this visit.
-She continued to discuss her stomach pain and the psychotherapist shared that it could be a physical side effect of her anxiety.
-Resident #1 displayed avoidance when encouraged to participate in healthy coping skills and facility activities.
-She reported not being well enough to attend activities and was dismissive during the session.
-Her prognosis was fair but motivation was a barrier to treatment for this visit.

Telephone interview with Resident #1's Psychotherapist on 06/23/22 at 11:43am revealed:
-She usually saw Resident #1 bi-weekly due 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 _____	C 06/24/2022

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 338	Continued From page 24	D 338		

her schedule and case load; however, Resident #1 was approved for four visits per month.
-When she started to decline the facility's activities the Psychotherapist increased the amount of times she visited.
-She saw Resident #1 on 05/31/22, 06/07/22 and attempted on 06/15/22 but Resident #1 refused to participate in the session.
-Staff did not inform her that Resident #1 expressed feeling more depressed on 05/27/22.

Review of Resident #1's Psychiatrist's note dated 06/10/22 revealed:
-Resident #1 reported her moods had been fluctuating between sad and fine but denied thoughts of harming herself or others.
-Recommended that nursing continue to provide supportive care and safety precautions.
-An order to increase aripiprazole (a medication used to treat agitation that occurs with mood disorders) to 5mg daily.

Telephone interview with Resident #1's Psychiatrist on 06/22/22 at 11:12am revealed:
-She increased Resident #1's aripiprazole to help stabilize her moods on 06/10/22.
-She documented "nursing to continue to provide supportive care and safety precautions" in her patients notes and expected staff to report any changes in mood and monitor for falls due to over sedation from medications.
-She never felt like Resident #1 was a danger to herself, and the fact that she lived on the third floor with her mental health history never crossed her mind.
-She did not know that Resident #1's window was able to be easily opened.

Review of Resident #1's accident/incident report dated 06/15/22 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 06/24/2022

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 338	Continued From page 25 -A staff member was asked to search the building for Resident #1. -Resident #1 could not be found so a MA unlocked her room and saw that a window was open. -The staff member looked out the window and saw Resident #1 face down on the grass. -The local law enforcement and 911 were called. Interview with a third MA on 06/15/22 at 11:04 pm revealed: -She was the MA assigned to administer medications to Resident #1 today (06/15/22). -She pulled the medications at 3:50pm and knocked on Resident #1's door. -Resident #1's room door was usually opened, but today, the door was locked. -When Resident #1 did not answer, she used her key to open the door. -She stuck her head in the room and called out Resident # 1's name but did not go all the way into the room. -When she did not receive a response, she backed out of the room and locked the door. -She called the front desk to see if Resident #1 was out of the facility with her family. -The front desk reported that Resident #1 had not signed out with her family. -She called on the radio and asked if any staff had laid eyes on Resident #1. -She went downstairs to see if Resident #1 was in an activity. -She saw two other MAs who offered to help locate Resident #1. -The three MAs went back to the room to conduct a search of the room. -She unlocked the door to Resident #1's room and checked the bathroom, one MA went near the bed and the other MA went to the window because the window was wide opened.	D 338		

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 06/24/2022

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 338	Continued From page 26 -She observed Resident #1 lying face down on the ground. -She radioed the nurse. Interview with the RCD on 06/23/22 at 11:00am revealed: -She started working at the facility on 05/31/22 (two weeks prior to Resident #1's accident) and had never met Resident #1 face to face. -All of the residents in the facility should be checked on by staff every two hours. -When staff checked on residents they should actually lay eyes on them and confirm that they were safe. -The Psychiatrist's recommendation for safety precautions meant to check on residents every two hours and to encourage residents to attend activities. -There was no current documentation that the staff were checking on residents every two hours and best practice would be to document these occurrences. -She was not made aware of Resident #1 making statements to staff about a change in her mood. -The previous RCD's documentation would show up on the facility's Clinical Notes Report but she did not have access to any other documentation from the previous RCD. -If Resident #1 made a comment related to a change in her mood she would expect staff to notify herself or the RCC. -Whoever was notified would evaluate Resident #1 and her Psychiatrist would have been notified, all of this should have been documented. -After her Psychiatrist was notified Resident #1 would have been monitored more frequently than every two hours. -Resident #1 should have also been evaluated to see if she required professional mental health evaluation in the ED.	D 338		

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 06/24/2022

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 338	Continued From page 27	D 338		

-If she refused to go to the ED then Resident #1 would require one-hour mandatory checks from staff and they would be encouraged to check on her every 30 minutes if possible.
-When a resident required more than every two hour checks they were considered to be in the "Hot Box" (a term used to alert staff about a resident's increased needs related to health/safety concerns).
-Anytime a resident was put into the "Hot Box", and they are checked on it should be documented.
-Anyone who experienced recent falls, extreme weight loss, behavior changes or return from a hospitalization were to be placed in the "Hot Box".
-The amount of time that a resident spent in the "Hot Box" depended on the reason they were placed in it.
-She was not aware that suicidal was checked on the front of Resident #1's Care Plan.
-Due to this she would have expected the facility to provide a sitter or look for alternative placement for Resident #1.
-Resident #1's required level of care and the appropriateness of the current care setting should have been discussed at a Care Plan meeting with her family.

Telephone interview with the previous RCD on 06/23/22 at 12:06pm revealed:
-She spoke to Resident #1's family frequently and discussed any concerns that the facility had about Resident #1.
-Due to the frequent contact with her family, they did not come in for a formal Care Plan meeting.
-All of the staff were aware of the suicidal comments that Resident #1 made and her family was aware as well.
-Resident #1 would make comments about wanting to die then say that she did not mean it or

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 06/24/2022

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 338	Continued From page 28	D 338		

would not do anything about it.
-The previous RCD expected that all of the staff knew she was suicidal since they knew about her hospitalizations related to suicidal ideations.
-When Resident #1 made suicidal comments the facility would send her to the ED to be evaluated and see if she was still appropriate to live at the facility.
-When she came back from the hospital she was placed in "Hot Box" status and was checked on more frequently than other residents.
-Resident #1 would be checked on exactly every two hours or less, could not quantify a time period for less than every two hours, since most residents were checked on around every two and half hours.
-All staff knew that she needed to be checked on more frequently than other residents and this was communicated in morning stand up meetings.
-There was no documentation that Resident #1 was being checked on frequently and she could not ensure that staff were actually doing it.
-The facility would only check on her more frequently after she returned from the hospital and did not implement long term frequent staff check ins for Resident #1 due to her having routine visits with a Psychiatrist and a psychotherapist.
-Resident #1 talked to her multiple times in May 2022 to let her know that she was feeling more depressed or anxious and wanted to speak to her Psychiatrist about changing her medications.
-She did not document these conversations with Resident #1 or that she contacted the Psychiatrist.
-The facility did not put her in the "Hot Box" or implement any other inventions while waiting for the Psychiatrist's interventions.
-She was not aware that Resident #1 told a MA that she was feeling depressed on 05/27/22.

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 06/24/2022

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 338	Continued From page 29	D 338		

-The MA should have informed her of Resident #1's comment so she could have contacted the Psychiatrist.
-The facility allowed families and residents to choose their own rooms and that is why Resident #1 was living on the third floor.
-Management (RCD, RCC, Administrator and MCC) did not think about moving her off of the third floor but they did contemplate not readmitting her after her admission to the behavioral health hospital.
-She was unsure what influenced them to readmit her but remembered that it was going to be a "trial stay" to see how she behaved when she came back.
-Resident #1 was much happier when she discharged from the behavioral health hospital and management did not see the need to pursue alternative placement for her.

The facility's Hot Box policy was requested but was not available for review prior to exit on 06/24/22.

Telephone interview with Resident #1's Psychiatrist on 06/24/22 at 9:03am revealed:
-If the facility thought Resident #1 was unsafe or unstable then she would have recommended that they monitor more frequently then every two hours and send her to the ED for interventions.
-The facility never communicated with her that Resident #1 was unsafe unless they had already sent her to the ED.

Interview with a MA on 06/24/22 at 10:40am revealed:
-The "Hot Box" was for residents that were on antibiotics, had a urinary tract infection, recent fall or anyone who was not at their baseline.
-If she noticed anything different about the

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 06/24/2022

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 338	Continued From page 30	D 338		

resident then that would be recorded on a 24-hour shift sheet; however, she did not monitor the Resident #1 more frequently than other residents.
-If a resident needed to be checked on every hour then that would be communicated by word of mouth.
-When she ended her shift and counted off medications to the next MA she would also discuss whoever was on the 24 hour shift sheet but she was not trained to do this.

Interview with the Administrator on 06/24/22 at 10:00am, 2:59pm and 6:00pm revealed:
-All staff members (PCAs, MAs, and Supervising MAs) were responsible for checking on the residents.
-Residents should be checked every two hours and if a resident needed more frequent checks, then they should be checked hourly.
-Communication about increased care and supervision needs was through the RCD or RCC to the Supervising MA on each shift via text, a phone call, or face to face conversation.
-The Supervising MA would inform the MAs of any changes and discuss information on the residents.
-If there were not any changes in resident care or supervision to discuss then there would not be a pre-shift meeting between the Supervising MAs and MAs.
-One hour frequent checks or every two-hour checks were not documented.
-Resident #1 did not require increased daily frequent checks and should have been checked on every two hours like other residents.
-She expected Resident #1 would have been in the "Hot Box" for 72 to 120 hours after each hospitalization which required her to be checked on every waking hour by staff.

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 06/24/2022

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 338	Continued From page 31	D 338		

-This was not a new procedure and had been in place for "a while".
-Staff should have been informed about the residents' "Hot Box" status by the 24-hour shift report sheet.
-Each time Resident #1 left "Hot Box" status, the Administrator thought she was safe and never thought that she required a sitter.
-If she thought Resident #1 was contemplating harming herself, she would have moved her to down to the first floor.
-She thought the child proof latches were enough for restricting the window opening in her room.

Review of the 24-hour shift documentation for Resident #1 from 02/22/22 to 02/26/22 revealed:
-Resident #1 returned to the facility on 02/22/22.
-There was no documentation of frequent checks for Resident #1 from 02/22/22 to 02/25/22.
-There was no 24-hour shift document available for review for 02/26/22.

Attempted telephone interview with Resident #1's family member 06/22/22 at 4:03pm was unsuccessful.

Attempted telephone interview with the RCC on 06/24/22 at 12:28pm was unsuccessful.

Attempted telephone interview with Resident #1's PCP on 06/24/22 at 9:44am was unsuccessful.

[Refer to tag D0049 10A NCAC 13F .0305(d) Physical Environment (Type A1 Violation)]

[Refer to tag D0433 10A NCAC 13F. 1201(a) Resident Records (Standard Deficiency)]

_____

The facility failed to ensure adequate and appropriate care for Resident #1 with a history of

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 06/24/2022

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 338	Continued From page 32 three hospitalizations related to suicidal ideations and was an imminent risk to herself, who fell from her third story window to her death. This failure resulted in serious neglect and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/21/22 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 24, 2022.	D 338		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 8 sampled residents (#5 and #8) had a physician's order to self-administer a pain reliever.	D 375		

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 06/24/2022

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 375	Continued From page 33	D 375		

The findings are:

1. Review of Resident #5's current FL2 dated 04/08/22 revealed:
-Diagnoses included osteoarthritis and chronic anxiety.
-Resident #5 was ambulatory with a walker.

Review of Resident #5's signed Physician Order Sheet dated 01/27/22 revealed an order for extra strength Tylenol (a medication for pain relief) 500 mg, two tablets three times a day as needed.
-There was no order to self-administer extra strength Tylenol.

Interview with Resident #5 on 06/21/22 at 11:30am revealed she had a bottle of Tylenol in her room because she never knew how long it would take the medication aide (MA) to bring her medication.

Review of Resident #5's April 2022 electronic Medication Administration Record (eMAR) revealed:
-There was no entry for extra strength Tylenol 500 mg three times a day as needed.
-There was no entry on the eMAR indicating the extra strength Tylenol was self-administered.

Review of Resident #5's May 2022 eMAR revealed:
-There was no entry for extra strength Tylenol 500 mg three times a day as needed.
-There was no entry on the eMAR indicating the extra strength Tylenol was self-administered.

Review of Resident #5's June 2022 eMAR revealed:
-There was an entry for extra strength Tylenol 500

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 06/24/2022

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 375	Continued From page 34	D 375		

mg three times a day as needed.
-There was no entry on the eMAR indicating the extra strength Tylenol was self-administered.

Refer to interview with the personal care assistant (PCA) on 06/23/22 at 11:15am.

Refer to interview with the MA on 06/24/22 at 10:20am.

Refer to interview with the Resident Care Director (RCD) on 06/24/22 at 4:56pm.

Refer to interview with the Administrator on 06/24/22 at 6:00pm.

2. Review of Resident #8's FL2 dated 06/07/22 revealed:
-Diagnoses included lumbar fracture and osteoporosis.
-Resident was ambulatory with a walker.

Observation of Resident #8's room on 06/21/22 at 11:10am revealed:
-The resident was seated in a chair and a small table was next to her chair.
-On the table was a bottle of Tylenol 500 mg.
-The bottle's foil safety had been punctured and the level of the medication appeared to be close to the level of a new, full bottle.

Review of Resident #8's physician orders dated 06/07/22 revealed an order for Tylenol extra strength (a medication for pain relief) 500 mg two tablets every six hours daily.
-There was no order to self-administer acetaminophen extra strength.

Review of Resident #8's June 2022 eMAR 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 06/24/2022

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 375	Continued From page 35 -There was an entry for Tylenol extra strength 500 mg, 2 tablets scheduled at 12 midnight, 6am, 12 noon and 6pm. -There was no entry on the eMAR indicating the acetaminophen extra strength was self-administered. Interview with Resident #8 on 06/21/22 at 11:10am and 06/24/22 at 10:55am revealed: -She was recently admitted to the facility because of a broken back. -The Tylenol extra strength was ordered for 12 midnight, 6am, 12 noon and 6pm. -There were some nights the Tylenol was not administered in the middle of the night. -She had brought it to the Medication Aides' (MA) attention she needed it every six hours. -The staff knew she had the medication in her room. -She had not taken any of the medication from the bottle. -She thought her daughter had probably punctured the seal on the bottle for her. Refer to interview with the PCA on 06/23/22 at 11:15am. Refer to interview with the MA on 06/24/22 at 10:20am. Refer to interview with the RCD on 06/24/22 at 4:56pm. Refer to interview with the Administrator on 06/24/22 at 6:00pm. _____ Interview with a PCA on 06/23/22 at 11:15am revealed: -She never saw any medications in resident rooms.	D 375		

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 06/24/2022

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 375	Continued From page 36 -If she saw medication in a resident room, she would tell the MA and let her handle it. Interview with a MA on 06/24/22 at 10:20am revealed: -There were no residents on the hall who had orders for self-administration that she knew of. -She observed for any medication in the rooms when she gave medications. -She did not know if the PCA's checked when they were in the rooms for medication. -If she saw medications in the room, the resident would be made aware the medication would need to be removed until an order was received from the physician and an assessment was done for self-administration. Interview with the RCD on 06/24/22 at 4:56pm revealed: -She and the resident care coordinator (RCC) were responsible for getting self-administration orders and doing the assessments. -The RCC was currently on leave, and it would be her responsibility to ensure the self-administration order and assessment was in place until the RCC returned from leave. -When new admissions came in with medications, the medications were placed on the medication carts until a self-administration order and assessment was completed. -Resident #5 and Resident #8 did not have an order for self-administration of the Tylenol and a self-administer assessment had not been completed. -If staff saw medications in the room, they were to make the MA aware, and the MA would make the RCC or her aware. -She would need to re-educate the families and the staff on self-administration of medications.	D 375		

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 06/24/2022

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 375	Continued From page 37 Interview with the Administrator on 06/24/22 at 6:00pm revealed: -The assessments and self-administration orders were to be done. -The facility nurse was to obtain the residents' self-administration orders and complete a resident's assessment prior to the resident self-administering their medications. -She did not know the residents had medications they were self-administering in their rooms.	D 375		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter;	D 433		

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 06/24/2022

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 433	Continued From page 38 (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to maintain resident records in an orderly manner and readily available for review for 1 of 8 sampled residents (#1). The findings are: Review of Resident #1's current FL2 dated 02/17/22 revealed: -Diagnoses included hypertension and major depressive disorder. -The recommended level of care was assisted living facility. Interview with a medication aide (MA) on 06/15/22 at 11:20pm revealed: -She provided copies of Resident #1's face sheet and current list of medication. -She reported the facility was paperless and everything was in the computer. -She attempted to pull-up the FL2, care plan, and the resident's register without success.	D 433		

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 06/24/2022

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 433	Continued From page 39	D 433		

-The MA asked two other MAs to assist with pulling up documents, but the two MAs confirmed that the MAs did not have access to those documents.
-The MA was unable to print a copy of the electronic Medication Administration Record (eMAR).
-If a resident was sent out for an emergency, the medics were only given a copy of the resident's face sheet and current list of medications that were preprinted for all residents and kept in a notebook.
-The Resident Care Director (RCD) and the Resident Care Coordinator (RCC) were the two people that could pull up the documents requested and to print the documents.
- The RCC was coming to the facility to print the requested documents.

Telephone interview with Resident #1's Psychiatrist on 06/24/22 at 9:03am revealed:
-She came into the facility on scheduled visits.
-She saw Resident #1 on 10/24/21, 11/01/21, 11/29/21, 12/13/21, 12/27/21, 01/24/22, 03/07/22, 04/18/22, 05/13/22 and 06/10/22.

Review of Resident #1's record from 06/21/22 to 06/24/22 revealed:
-On 11/12/21, it was documented in the facility's Clinical Notes Report Resident #1 was seen by gastroenterology.
-There was no gastroenterology visit note in Resident #1's record.
-On 09/12/21, it was documented in the facility's Clinical Notes Report Resident #1 was sent to the hospital.
-There were no hospital records for the 09/12/21 hospital stay.
-There were no psychiatry notes for visits on 11/29/21, 12/13/21, 12/27/21, 01/24/22 and

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 06/24/2022

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 433	Continued From page 40	D 433		

03/07/22.
-Resident #1's FL2, dated 02/17/22, was not available until 06/23/22.
-Resident #1's Primary Care Provider's (PCP) visit notes, dated 04/19/22, 05/17/22, and 06/14/22, were not available until 06/23/22.

Interview with a MA on 06/24/22 at 4:40pm revealed:
-She had a binder on the medication cart that had residents' face sheets, insurance cards and medication lists.
-If she needed any of the residents' FL2s after normal business hours she would have to call the RCC or RCD because the FL2s were kept on a desktop that she did not have access to them.
-The RCD would have to access the information from home and possibly send it directly to the hospital.
-The MA was responsible for collecting the hospital discharge paperwork, for any resident that returned to the facility after normal business hours, and putting it in a binder for the Nurse Practioner (NP) to review.

Interview with the Administrator on 06/24/22 at 5:59pm revealed:
-The MAs had access to the facility's electronic database where they could find the residents' face sheet and medication list then send the documents to the printer at the front desk.
-When residents came back from the hospital the discharge packet should be given to the RCC or RCD.
-If the RCC or RCD were not working then the Supervising MA would put the paperwork in a folder in the RCD's office.
-She thought the facility physicians sent their notes electronically to the facility on the day that the resident was seen by them at 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 06/24/2022

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 433	Continued From page 41 -The RCC and RCD were responsible for ensuring that the resident's records were complete. -They were expected to audit a sample of records monthly for completion. -She expected the resident's records to be easily retrieved to be reviewed.	D 433		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure residents were free from neglect and physical harm related to resident rights and the environment. The findings are: 1. Based on interviews, observations and record reviews the facility failed to ensure residents were safe from neglect for 1 of 7 sampled residents who expressed suicidal ideations with history of suicide attempts and hospitalizations resulting in the resident falling from a third story window, (Resident #1). [Refer to Tag 338 10A NCAC 13F .0909 Residents Rights (Type A1 Violation)]. 2. Based on observations and interviews the facility failed to restrict a window opening to six-inches for a resident with history of attempted suicide with access to unrestricted 3rd floor	D914		

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 06/24/2022

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
D914	Continued From page 42 window (Resident #1). [Refer to Tag 049 10A NCAC 13F .0305(d) Physical Environment (Type A1 Violation)].	D914		