

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CHARLOTTE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 Mecklenburg County Department of Social Services conducted an annual and follow-up survey on April 25 - 26, 2023.	D 000	The following is the Plan of Correction for The Charlotte Assisted Living and Memory Care regarding the Statement of Deficiencies dated 4/26/23. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as a confirmation of our on going efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.	
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 1 of 5 sampled residents (Resident #2) who had an order for physical therapy and occupational therapy due to a recent left hip fracture with open reduction and internal fixation repair.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL2 dated 03/25/23 revealed: -Diagnoses included fall, left hip fracture with open reduction and internal fixation and peripheral vascular disease. -Resident #2 was oriented. -Resident #2 was semi-ambulatory. -There was an order for physical therapy (PT) daily.</p> <p>Review of Resident #2's Resident Register dated 03/27/23 revealed an admission date of 03/28/23.</p> <p>Review of Resident #2's physician order summary revealed there was an order dated 03/25/23 for PT and occupational therapy (OT) evaluation and treatment.</p>	D 273		<p>10A NCAC 13F .0902(b) Health Care:</p> <p>1) Community contacted Resident #2's physician to obtain new PT and OT orders since the original orders being from out of state were the reason for the delay due to insurance reasons. Community also contacted another Home Health, PT and OT provider that would bill Medicare part A so that the resident would not have to pay copays. Before orders could be implemented, resident #2's responsible party took her out of the community to move back to New Jersey.</p>

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Holly G. Gause

TITLE

Executive Director

(X6) DATE

6-1-23

Reviewed and acknowledged on 06/09/23 by Jennifer Fender RN / jbf

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2023
NAME OF PROVIDER OR SUPPLIER THE CHARLOTTE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 273	Continued From page 1 Review of Resident #2's Primary Care Provider (PCP) admission History and Physical dated 04/12/23 revealed: -A new PT evaluation listed under Chief Complaint/Reason for visit. -There was PT and OT as needed/indicated listed under Assessment and Plan. Interview with Resident #2's Power of Attorney (POA) on 04/25/23 at 2:32pm and on 04/26/23 at 10:19am revealed: -She was aware that Resident #2 had not received PT or OT services. -She was notified on 03/27/23 by the facility's Physical Therapy Director that Resident #2 would have a \$40 out of pocket expense per discipline and per visit for outpatient PT and OT offered in the facility. -She did not want to pay additional costs if possible due to paying the private pay rate for room and board at the facility. -She was notified of possible insurance coverage for home health PT and OT services by the Physical Therapy Director. -She was agreeable with the facility to make the home health PT and OT referral. -She was notified of two home health agencies that the facility used, and she did not have a preference. -She was notified by the Physical Therapy Director that the facility would make the referral for home health PT and OT services. -No one from the facility had contacted her related to home health PT and OT services after the initial phone call with the Physical Therapy Director. Interview with Resident #2 on 04/25/23 at 3:07pm revealed:	D 273	2) RCD and/or RCC are responsible for ensuring that all new orders for referral and follow-up are implemented. RCD and RCC have been re-inserviced on this process and utilization of the new order tracking tool. 3) Community has audited all new move in paperwork from the last 90 days to assure that all orders including PT/OT orders have been implemented. 3) RCD and/or RCC will utilize a New Order tracking form to help track the timely implementation of new orders for referral and follow up, to ensure that all new orders are followed through with in a timely manner. 4) To assist with compliance, the Executive Director or designee will review New Order tracking forms for completion for the next three months.	5/26/23 5/26/23 5/26/23 5/26/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2023
NAME OF PROVIDER OR SUPPLIER THE CHARLOTTE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 273	<p>Continued From page 2</p> <p>-She was waiting for PT and OT to start. -She was aware that her insurance did not fully cover Pt and OT through the facility outpatient therapy services.</p> <p>Interview with Physical Therapy Director at the facility on 04/26/23 at 9:35am revealed: -He knew that Resident #2 had an order for Pt and OT. -He submitted Resident #2's insurance information to the therapy billing department. -He notified Resident #2's POA on 03/27/23 of a \$40 out of pocket cost per therapy and per therapy session. -He made Resident #2's POA aware of home health PT and OT services which POA was agreeable for the facility to make the referral due to the out of pocket cost of outpatient PT/OT. -He notified the Resident Care Director (RCD) the following morning (03/28/23) in the facility morning meeting that Resident #2's POA was agreeable with a home health PT and OT referral.</p> <p>Interview with the RCD on 04/26/23 at 9:54am revealed: -She was aware that Resident #2 needed a home health referral for PT and OT services. -She was notified by the Physical Therapy Director, along with the Resident Care Coordinator (RCC) of the need for a home health PT and OT referral during the facility morning meeting but was uncertain of the date. -She said the RCC had contacted Resident #2's POA and provided the POA with the contact information for two home health agencies that visited the facility but uncertain when contact was made. -She did not follow up with the RCC, POA or Resident #2 to see if home health PT and OT services had been referred to a home health</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CHARLOTTE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 273	<p>Continued From page 3</p> <p>agency.</p> <p>-She did not notify Resident #2's Primary Care Provider (PCP) that home health PT and OT services had not been implemented.</p> <p>Review of Resident #2's record on 04/26/23 revealed:</p> <p>-There was no documentation that the RCC had contacted the POA regarding a home health referral.</p> <p>-There was no documentation that the facility had made a home health referral.</p> <p>Interview with the RCC on 04/26/23 at 10:42am revealed:</p> <p>-She was aware that Resident #2 needed a home health referral for PT and OT services.</p> <p>-She was notified by the Physical Therapy Director, along with the RCD of the need for a home health PT and OT referral during the facility morning meeting but was uncertain of the date.</p> <p>-She states she called Resident #2's POA a couple weeks after Resident #2 was admitted and provided the POA with the contact information for two home health agencies that visited the facility.</p> <p>-She said the POA was to call the home health agencies to see if either agency accepted Resident #2's insurance.</p> <p>-She did not follow back up with Resident #2's POA.</p> <p>Attempted telephone interview with Resident #2's PCP on 04/26/23 at 11:23am was unsuccessful.</p> <p>Interview with the Administrator on 04/26/23 at 10:50am revealed:</p> <p>-She did not know Resident #2 needed a home health PT and OT referral made.</p> <p>-She did not know why the home health referral was not made by the facility.</p>	D 273		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2023
NAME OF PROVIDER OR SUPPLIER THE CHARLOTTE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 273	Continued From page 4 -She expected the RCD and the RCC to implement all physician orders and referrals. -She expected RCD and RCC to follow up with all referrals to ensure services were in place. -She expected the RCD to check behind the RCC to ensure all physician orders and referrals were processed correctly. -There was no process in place to ensure all orders and referrals had been processed or implemented correctly.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (Resident #2) related to daily blood pressure checks. The findings are: Review of Resident #2's current FL2 dated 3/25/23 revealed: -Diagnoses included fall, left hip fracture with open reduction and internal fixation, hypertension, and peripheral vascular disease. -There was an order for daily blood pressure (BP) checks.	D 276	10A NCAC 13F .0902 (c)(3-4): 1) Community added the daily BP order to resident #2's treatment orders on the eMar system and blood pressures were performed daily thereafter. Resident #2 moved out of the community shortly after the survey or the community would have contacted her physician for clarification as to whether daily BPs were appropriate. 2) RCD and/or RCC are responsible for assuring the implementation of procedures, treatments, and orders. RCD and RCC have been re-inserviced on assuring the implementation of procedures, treatments, and orders. 3) RCD will audit 10% of resident records on a monthly basis to ensure that procedures, treatments and orders are correct, on the MAR, and being implemented as ordered. 4) To assist with compliance, the Executive Director will review the audit log for the next three months.	4/28/23 5/26/23 5/26/23 5/26/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/26/2023
NAME OF PROVIDER OR SUPPLIER THE CHARLOTTE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 276	Continued From page 5 Review of Resident #2's Resident Register dated 03/27/23 revealed an admission date of 03/28/23. Review of Resident #2's March and April 2023 electronic medication administration record (eMAR) revealed there was no entry for BP checks. Review of Resident #2's Primary Care Provider (PCP) admission History and Physical dated 4/12/23 revealed: -A blood pressure on 04/12/23 was within range at 140/60. -The blood pressure goal was documented as 140/90 or less. Interview with the Resident Care Coordinator (RCC) on 04/25/23 at 3:07pm revealed: -She did know Resident #2 had an order for daily BP checks. -She and the Resident Care Director (RCD) were responsible for implementing all orders. -She and the RCD were responsible for entering all orders on to the eMAR. -She missed the order for daily BP checks on Resident #2's FL2. Attempted telephone interview with Resident #2's Primary Care Provider on 04/26/23 at 11:23am was unsuccessful. Interview with the RCD on 04/26/23 at 12:11pm revealed: -She did know Resident #2 had an order for daily blood pressure checks. -She and the RCC were responsible for implementing all orders. -She and the RCC were responsible for entering all orders on to the eMAR. -She did not clarify the order for daily BP checks	D 276			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/26/2023
NAME OF PROVIDER OR SUPPLIER THE CHARLOTTE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 276	Continued From page 6 or notify Resident #2's PCP that daily BP checks were not implemented. -She missed the order for daily BP checks on Resident #2's FL2. Interview with the Administrator on 04/26/23 at 2:32pm revealed: -She did not know Resident #2 had an order for daily BP checks. -The RCD and RCC were responsible for implementing all orders. -She expected the RCD to check behind the RCC to ensure all orders were processed correctly. -There was no process in place to ensure all orders had been processed or implemented correctly. -She expected the RCC and/or RCD to obtain clarification orders from Resident #2's PCP.	D 276			
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 observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (Resident #3) related to a medication to lower blood sugar.	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CHARLOTTE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 7</p> <p>Review of Resident #3's current FL2 dated 05/19/22 revealed diagnoses included diabetes, dementia, vascular disease, and hypertension.</p> <p>Review of Resident #3's current signed physician orders dated 03/15/23 revealed Novolog Flexpen U-100, check fingerstick blood sugar (FSBS) every morning before meals and at bedtime and inject per sliding scale: FSBS: 301-350 = 8 units, 351-400 = 10 units, if greater than 400 call the primary care physician (PCP).</p> <p>Review of Resident #3's February 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry to give Novolog Flexpen U-100 three times daily: FSBS: 301-350 = 8 units, 351-400 = 10 units, if greater than 400 call pcp. -Her FSBS on 02/03/23 at 8:00pm was 312 and she received no Humalog insulin per the documentation, when 8 units should have been administered. -Her FSBS on 02/04/23 at 8:00pm was 307 and she received no Humalog insulin per the documentation when 8 units should have been administered. -Her FSBS on 02/05/23 at 7:00am was 301 and she received no Humalog insulin per the documentation when 8 units should have been administered. -Her FSBS on 02/12/23 at 8:00pm was 328 and she received no Humalog insulin per the documentation when 8 units should have been administered. -Her FSBS on 02/16/23 at 8:00pm was 316 and she received no Humalog insulin per the documentation when 8 units should have been administered. -Her FSBS on 02/17/23 at 8:00pm was 327 and</p>	D 358	<p>10A NCAC 13F .1004 Medication Administration:</p> <p>1) Community added the physical monitor to the eMar system so that administration could be documented properly, which is what was missing at the time of survey. Community is taking and recording blood sugars in the eMar system as ordered and administering the sliding scale insulin as ordered and properly documenting in the eMar system.</p> <p>2) RCD and/or RCC are responsible for ensuring that Medication Administration is in accordance to physician's orders and is documented.</p> <p>3) Staff responsible for the administration of Medications have been re-inserviced on the proper documentation of Medication Administration and following physician's orders.</p> <p>4) Staff responsible for the administration of Medications have been re-inserviced on the proper administration and documentation of administration of sliding scale insulin.</p> <p>5) RCD and/or RCC will perform monthly MAR audits to ensure accuracy of eMars</p> <p>6) To assist with compliance, the Executive Director will review the Monthly Audit logs for the next three months.</p>	<p>4/26/23</p> <p>5/26/23</p> <p>5/26/23</p> <p>5/26/23</p> <p>5/26/23</p> <p>5/26/23</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CHARLOTTE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 8</p> <p>she received no Humalog insulin per the documentation when 8 units should have been administered.</p> <p>-Her FSBS on 02/18/23 at 8:00pm was 355 and she received no Humalog insulin per the documentation when 10 units should have been administered.</p> <p>-Her FSBS on 02/19/23 at 8:00pm was 306 and she received no Humalog insulin per the documentation when 8 units should have been administered.</p> <p>Review of Resident #3's March 2023 eMAR revealed:</p> <p>-There was an entry to give Novolog Flexpen U-100 three times daily: FSBS: 301-350 = 8 units, 351-400 = 10 units, if greater than 400 call pcp.</p> <p>-Her FSBS on 03/02/23 at 8:00pm was 304 and she received no Humalog insulin per the documentation when 8 units should have been administered.</p> <p>-Her FSBS on 03/03/23 at 8:00pm was 310 and she received no Humalog insulin per the documentation when 8 units should have been administered.</p> <p>Interview with the Special Care Unit (SCU) medication aide (MA) on 04/26/23 at 9:37am revealed:</p> <p>-The MAs were responsible for checking Resident #3's FSBS before breakfast, before lunch and at bedtime.</p> <p>-The eMAR did not populate the sliding scale insulin to be administered after the FSBS was documented.</p> <p>-She would put the amount of sliding scale administered to Resident #3 in an administrative note but was unable to pull the administrative note up.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/26/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CHARLOTTE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 9</p> <p>-She had training on diabetic care and documentation but could not remember when it was.</p> <p>-She was not sure if the resident records were audited but knew the pharmacy came and reviewed all the records on the SCU quarterly.</p> <p>Interview with the Resident Care Coordinator (RCC) on 04/26/23 at 9:56am revealed:</p> <p>-All eMARs were printed by the facility.</p> <p>-The RCC did not realize there was no area on the eMAR to document the amount of Humalog administered.</p> <p>-The eMAR did not populate the amount of sliding scale to be administered after the FSBS was documented.</p> <p>-Facility staff were auditing the charts for the entire facility and had finished up the 100 hall and were working on the 200 hall.</p> <p>Interview with the Information Technology Technician (IT) on 04/26/23 at 10:15am revealed:</p> <p>-He was not aware there was not a place to document the amount of sliding scale insulin administered for Resident #3.</p> <p>-He was not aware there was no prompting on the eMAR to document the amount of sliding scale insulin administered for Resident #3.</p> <p>-The facility printed their own monthly eMARs.</p> <p>Interview with the Administrator on 04/26/23 at 2:25pm revealed:</p> <p>-She was not aware there was no place on the eMAR to document the amount of sliding scale insulin administered after the FSBS was done.</p> <p>-She would assume there had been training for residents on sliding scale insulin, but more training would be completed since IT had changed the form for sliding scale insulin and the form populating the amount of sliding scale</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/26/2023
NAME OF PROVIDER OR SUPPLIER THE CHARLOTTE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 10 insulin to be administered. -Training would be completed by the RCC, the facility registered nurse (RN) and IT immediately. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/26/23 at 1:35pm revealed: -Resident #3's current sliding scale insulin order was Novolog 100, check FSBS every morning before meals and at bedtime and inject per sliding scale: FSBS: 301-350 = 8 units, 351-400 = 10 units, if greater than 400 call the PCP. -A Novolog 100-unit Flexpen was last dispensed on 03/08/23, 02/08/23 and 12/01/22. -The facility printed their own eMARs. -Audits were completed by a team of pharmacists quarterly and they looked at every chart. -If Resident #3 did not receive her insulin it could cause hyperglycemia with symptoms of agitation, nausea, and drowsiness. Attempted interview with Resident #3's PCP on 04/26/23 at 10:35am was unsuccessful.	D 358			