STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060158	A. BUILDING: _____ B. WING _____	R 05/07/2025

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 Adcult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and follow-up survey from May 6, 2025 to May 7, 2025.	D 000		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to document the administration of a medication on the Electronic Medication Administration Record (eMAR) for 1 of 5 sampled residents (Resident #1) related to	D 367		

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D 367	Continued From page 1 oxygen. The findings are: Review of Resident #1's current FL2 dated 05/22/24 revealed: -Diagnoses included diabetes chronic kidney disease stage 3, chronic obstructive pulmonary disease, and hypertension. -There was an order for oxygen 2 liters per minute (LPM) via nasal canula as needed (PRN) for dizziness. Review of Resident #1's physician order dated 01/17/25 revealed there was an order for oxygen 2 LPM continuous via nasal canula. Observation of Resident #1 on 05/06/25 and 05/07/25 revealed he was using oxygen 2 LPM continuous via nasal canula. Review of Resident #1's March 2025, April 2025 and May 2025 (eMARs) revealed there was no order entered for oxygen 2 LPM continuous via nasal canula. Interview with a medication aide (MA) on 05/07/25 at 1:54pm revealed: -She did not document Resident #1's oxygen on the eMAR becuase there was no order entered on the eMAR. -Resident #1 wore his oxygen at all times when he was in his room and used a portable oxygen tank when he was not in his room. Interview with Resident #1"s Primary Care Physician (PCP) on 05/07/25 at 12:37pm revealed: -Resident #1 had an order for oxygen 2 LPM continuously via nasal canula.	D 367		

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D 367	Continued From page 2 -Staff should be ensuring Resident #1 was on oxygen as ordered. Interview with the Resident Care Director (RCD) on 05/07/25 at 2:05pm revealed: -She and the Health and Wellness Director (HWD) were responsible for entering orders on the eMAR. -She did not know Resident #1's oxygen order was not entered on the eMAR. -She expected MAs to notify the RCD or HDW about discrepancies on the eMAR. Interview with the Administrator on 05/07/25 at 2:27pm revealed: -The eMAR or TAR system might of had a glitch and not allowed for an oxygen order to be entered or viewed for some residents. -She expected MAs to pull from an order list to clarify orders that should be displayed on the eMAR or TAR and document appropriately. -The current eMAR system was scheduled to transition to a new system by the end of 2025.	D 367		
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	D 375		

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D 375	Continued From page 3 medication label. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure 1 of 5 sampled residents (Resident #1) had a physician's order to self-administer a medication used to treat shortness of breath. The findings are: Review of Resident #1's current FL2 dated 05/22/24 revealed: -Diagnoses included diabetes chronic kidney disease stage 3, chronic obstructive pulmonary disease, and hypertension. -There was an order for albuterol sulfate inhaler (a medication to treat shortness of breath) 90 mcg, inhale 2 puffs every 6 hours as needed. Review of Resident #1's record revealed: -There was an order for albuterol sulfate HFA 90 mcg/ actuation aerosol inhaler 2 puffs every 6 hours as needed for shortness of breath. -There was no order for Resident #1 to self-administer his albuterol inhaler. Review of Resident #1's March 2025, April 2025, and May 2025 eMARs revealed there was no order entered for Resident #1 to self administer his albuterol inhaler. Interview with the medication aide (MA) on 05/07/25 at 11:50am revealed: -She could not locate the inhaler on the medication cart. -Resident #1 did not have an order to	D 375		

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D 375	Continued From page 4	D 375		

self-administer his albuterol inhaler as needed.

Observation of Resident #1 on 05/07/25 at 11:55am revealed Resident #1 removing his albuterol inhaler from his pants pocket.

Interview with Resident #1 on 05/07/25 at 11:55am revealed:
-He obtained the inhaler from a MA (unknown name) to use as needed and kept it in his room or in his pocket.
-He used the inhaler at times but did not use it recently.

Interview with Resident #1's Primary Care Physician (PCP) on 05/07/25 at 12:37pm revealed:
-Resident #1 had an order for albuterol inhaler 2 puffs as needed.
-Resident #1 did not have an assessment and/ or order to self-administer albuterol inhaler and did not know how he obtained the inhaler to keep in his room or on his person.
-Outcome related to overuse of or improper use of albuterol inhaler could result in increased anxiety and nervousness.
-Resident #1 was cognitive and able to self-administer albuterol inhaler although he needed an order to self-administer the inhaler.

Interview with the Resident Care Director (RCD) on 05/07/25 at 2:05pm revealed:
-She did not know Resident #1 was self-administering his albuterol inhaler.
-Resident #1's did not have a self-administration order for albuterol inhaler.
-She expected the MAs to read what's on Resident #1's treatment orders.

Interview with the Administrator on 05/07/25 at

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D 375	Continued From page 5 2:27pm revealed: -She did not know Resident #1 was self-administering his albuterol inhaler without an order for self-administration. -She expected communication between Resident #1, the PCP and the RCD related to a self-administration assessment followed by an order for self-administration if appropriate.	D 375		