Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060158	A. BUILDING: _____ B. WING _____	R-C 01/15/2026

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

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and a complaint investigation from January 13, 2026 through January 15, 2026.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure 1 of 5 sampled resident's trash was emptied daily in the assisted living (AL) side of the facility (#1). The finding are: Review of the facility's undated Step by Step Guide to Daily Cleaning of Rooms revealed: -To be completed every day in every room. -Take out trash, clean trash cans if needed with disinfectant and put new bag in. -If a adult brief was left in the trash, it was not to be removed and notify a personal care aide.	D 079	The Plan of Correction constitutes this facility's written allegation of compliance for the dificiency(s) cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. Each item included in the Plan of Correction (POC) below has been implemented and will continue to be consistent practice to ensure safety of all residents. Administrator, Resident Care Director, and/or Designee will be responsible for ensuring compliance in accordance with Rule 10A NCAC 13F .0306 Housekeeping and Furnishings, Rule 10A NCAC 13F .0802 Resident Care Plan, Rule 10A NCAC 13F .1002 Medication Orders, and Rule 10A NCAC 13F .1004 Medication Administration.	2.10.2026

Reviewed and acknowledged

by

on 02/10/26

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D 079	Continued From page 1 -Clean the outside and inside of the toilet. -Sweep and mop the bathroom floor. Review of Resident #1's current FL2 dated 12/11/25 revealed diagnoses included congestive heart failure, mild cognitive impairment, irritable bowel syndrome and ulcerative colitis. Telephone interview with a family member on 01/13/26 at 11:32am revealed: -On 12/20/26, he and his wife visited Resident #1 at the facility. -His wife found feces on the bathroom floor, cleaned it up and the trash had not been emptied in the bathroom and kitchenette. -On 12/21/26, during a visit with Resident #1, his wife found a pad containing feces on the bathroom floor and disposed of it. -On 01/22/26, he and his wife met with the Administrator and the Resident Care Director (RCD) and discussed the cleanliness of the bathroom and the trash that had not been emptied since 12/18/26. -The Administrator told him the trash in the bathroom, kitchenette and living room was to be emptied every shift and evey day. -On 01/23/25, he and his wife visited Resident #1 and the trash in the living room and kitchenette still had not been emptied. Interview with a housekeeper on 01/13/26 at 10:30am revealed: -One of her duties was to clean and empty the trash in the bathroom. -She did not empty the trash in the kitchenette and living room because that was the medication aides responsibility. -She would also assist with cleaning up in the bathroom after the initial cleaning was completed if the resident or family had called. for assistance.	D 079	Regarding 10A NCAC 13F .0306. Listed within the job duties of the job description of the Facilities Department, including but not limited to the Housekeeping Team Members, lists the removal of trash from residents' apartment. Both clinical department and housekeeping department team members are responsible for the removal of resident trash by the job duties within organizations' job descriptions and duties. While documentation of such services is not required per rule 10A NCAC 13F .0306, light housekeeping duties will continue to be offered during daily care. In addition, daily tasks in housekeeping have been added into the EMR for all caregivers and to validate completion. Director of Facility Services and/or Designee, will check random sample of apartments at once weekly to ensure trash removal has been completed and at standard. Resident Care Director and/or Designee, will take random sample of census weekly x4 to audit trash removal completion within the EMR tracking system. Following weekly audit, monthly x2 and ongoing or until 100% compliance is reached. Review of light housekeeping duties will be reviewed at Quality Assurance and Performance Improvement (QAPI) meeting by Interdisciplinary Team (IDT) for x3 months or until 100% compliance is satisfactory to the standard.	2.10.2026

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D 079	Continued From page 2 -Resident #1 had only been at the facility for a short time and she never met Resident #1's family. -On 12/22/26, the Administrator informed her that all housekeeping staff were responsible to check all trash containers in the resident's room and empty the trash if needed. Interview with the Administrator on 01/14/26 at 2:45pm revealed: -Housekeepers received training upon hire to empty trash in the resident's room every day and as needed. -Medication aides (MAs) and personal care aides (PCAs) were trained to empty trash if requested by the resident. -Housekeepers were trained to notify the MA if there was a soiled adult brief in the trash and the MA was responsible to remove the trash. -On 12/22/25, Resident #1's family met with her to discuss Resident #1's care and housekeeping concerns. -The family reported that the trash had not been emptied for 5 days and feces was found on the floor and toilet over the weekend. -On 12/22/25, after the meeting she met with housekeepers to remind them it was their responsibility to complete extra cleaning if needed/requested after the initial cleaning was completed. -Housekeepers were reminded to empty all trash in the resident's room and to notify a MA if there was a soiled adult brief in the trash for them to remove.	D 079		
D 263	10A NCAC 13F .0802 (f) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan	D 263		

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D 263	Continued From page 3 (f) The care plan shall be revised as needed based on the results of a significant change assessment completed in accordance with Rule .0801 of this Section. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 5 sampled residents (#2) had a care plan assessment completed within 10 days of a significant change when the resident was admitted to hospice care. The findings are: Review of Resident #2's current FL2 dated 12/12/25 revealed: -Resident #2's diagnoses included pulmonary fibrosis, atrial fibrillation, congestive heart failure and hyperlipidemia. -Resident #2 was ambulatory. -Resident #2's level of care was assisted living. Review of Resident #2's Resident Register revealed an admission date of 12/12/25. Review of Resident #2's care plan dated 12/12/25 revealed there was no documentation the care plan was updated to reflect a change in condition and hospice admission within ten days. Review of Resident #2's hospital discharge summary dated 12/18/25 revealed: -Resident #2 had a hospital from 12/15/25 to 12/18/25. -Resident #2 was admitted to the hospital due to worsening respiratory status.	D 263	Regarding 10A NCAC 13F .0802. Resident #2 was admitted to The Charlotte community on 12/12/2025. Due to consistent discussion on care needs prior to admission, initial Care Plan upon admission was completed on 12/12/2025. When Change in Condition occurred 12/18/2025 with a referral and admission to hospice service, Care Plan was communicated to Resident Care Coordinator of Assisted Livng at the time of Change in Condition. To ensure Change of Condition Care Plans are initiated when necessary and proper documentation is completed, Resident Care Director, Resident Care Coordinator(s), and/or Designee will review bi-weekly in "At Risk" Meeting starting February 4th 2026. All changes deemed as a Change in Condition, will be added to "At Risk" notes. Resident Care Director, Resident Care Coordinator(s), and/or Designee will audit bi-weekly the completion of Change in Condition Care Plans. Ongoing audits will be completed monthly x3 or until 100% compliance is reached.	2.10.2026

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D 263	Continued From page 4 -Resident #2's symptoms were treated with steroids until he returned to baseline. -Resident #2 opted to pursue hospice care due to his worsening chronic illness. -Resident #2 was to continue with Lasix (used to treat fluid retention) 40mg in the evenings, discontinue taking Ofev (used to treat lung disease) after completing the remaining tablets, continue taking steroids and taper the dose 40mg through 12/20/25, then 30 mg starting 12/21 for 5 days, then 20mg starting 12/26/25, then 10mg starting 12/31/25 for 5 days, then 5mg starting 1/5/26 for 5 days, and Pradaxa (used as a blood thinner) dosage was reduced to 75mg twice daily. -Resident #2 was discharged back to the facility with hospice services. Review of Resident #2's record revealed there was no documentation within 3 days that Resident #2 required a change in condition and care plan was not updated within 10 days of hospice admission. Review of Resident #2's hospice certification and plan of care revealed he was admitted to hospice services on 12/18/25 with diagnosis of end-stage pulmonary fibrosis. Interview with the Resident Care Director (RCD) on 01/15/26 at 1:46pm revealed: -The Resident Care Coordinator (RCC), who no longer worked at the facility, was responsible for recognizing a change in condition and updating the care plan because of the change in condition. -She was responsible for checking behind the RCC by running audits on FL2 forms and care plans to assure all symptoms and needs were identified. -The need for a change in condition would have been entered manually, and it was not.	D 263		

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D 263	Continued From page 5 -Resident #2 was sent to the hospital on 12/15/26 due to increased pulmonary symptoms. -Resident #2's increased symptoms should have been identified within three days, and the care plan should have been updated with a change in condition within 10 days and it was missed. -Resident #2 was admitted to hospice services when he was discharged from last hospital stay on 12/18/25. Interview with the Administrator on 01/15/26 at 2:53pm revealed: -The RCC was responsible for updating the care plan if there was a change in condition for any resident. -She was not sure why the change in condition was not done, although it was verbalized in the daily meeting. -Resident #2's change in condition should have been documented within ten days when it was decided he was to start with hospice services, and it was missed.	D 263		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's	D 344		

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D 344	Continued From page 6 record. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure medication was administered as prescribed for 1 of 5 sampled residents (#2), related to administering "as needed" medications in place of prescribed medications. The findings are: Review of Resident #2's current FL2 dated 12/12/25 revealed: -Resident #2's diagnoses included pulmonary fibrosis, atrial fibrillation, congestive heart failure and hyperlipidemia. -There was an order for 4 liters of continuous oxygen -Resident #2 was ambulatory. -Resident #2's level of care was assisted living. Review of Resident #2's Resident Register revealed an admission date of 12/12/25. Review of Resident #2's hospice admission orders dated 12/18/25 revealed: -There was an order for levsin .125mg (used to decrease secretions) as needed every four hours. -There was an order oxycodone 5mg (used to treat pain/ shortness of breath) as needed every four hours. a. Review of Resident #2's hospice admission physician dated 01/05/26 revealed there was an order for levsin .125mg, take one tablet by mouth at 6:00am and 6:00pm. Review of Resident #2's electronic medication administration record (eMAR) for December 2025	D 344	Referencing 10A NCAC 13F .1002 - Medication Orders and 10A NCAC 13F .1004(a) Medication Administration for orders with Resident #2. Resident #2 received admission to hospice services on 12/18/2025. While there are partnerships within communities, residents have autonomy to choose organization and/or service company that provides services they are seeking. Resident #2 and family chose a service company that did not yet have a footprint within The Charlotte organization. On date of Resident #2 admission to hospice organizations' services on 12/18/2025, Resident Care Director (RCD) met clinical admissions upon arrival to community. RCD discussed with hospice staff members, the following: medication order/change process, expectation of communication from hospice services to community and pharmacy services when/if changes were made, communication during each visit when onsite, and communication within binder along with location of hospice binder specific to their organization and patients. Expectation of hospice organization was to provide notes within binder when visiting, communicate with RCD while onsite, and all order updates/changes to be sent to pharmacy services along with copy of order to RCD. On the date of hopsice admission, hospice organization exerciesd this process by creating written orders of medication and DNR via written orders onsite of community. Orders for Oxygen were not communicated on order sheet nor verbally. Hospice clincal admissions staff member updated O2 order within their own system, fax was not provided to community nor pharmacy services. Formal in-service with hospice provider discussed to ensure consistent communication has been initiated, will be completed by February 27th 2026.	2.10.2026

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D 344	Continued From page 7 revealed there was an entry for levsin .125mg, give one tablet by mouth every 4 hours as needed for tracheal secretions with a start date of 12/19/25. Review of Resident #2's eMAR for January 2026 revealed: -There was an entry for levsin .125mg, give one tablet by mouth every 4 hours as needed for tracheal secretions. -There was an entry for levsin .125mg, give one tablet by mouth two times a day (6:00am and 6:00pm) for secretions. Observation of Resident #2's medications available for administration on 01/13/26 revealed: -There were two medication cards for levsin .125mg, give one tablet by mouth every four hours as needed for pain/ shortness of breath. -There was not a medication card for levsin .125mg, give one tablet by mouth two times a day (6:00am and 6:00pm) for secretions. Refer to the interview with the medication aide (MA) on 01/14/26 at 11:20am. Refer to the interview with the Resident Care Director (RCD) on 01/14/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. b. Review of Resident #2's hospice orders dated 01/05/26 revealed there was an order for oxycodone 5mg, take one tablet by mouth at 6:00am, 12:00pm, and 6:00pm. Review of Resident #2's medication administration record (MAR) for December 2025 revealed there was an entry for oxycodone HCl	D 344	Continued Referencing: 10A NCAC 13F .1002 and 10A NCAC 13F .1004(a). To ensure consistent practices with hospice vendors, Resident Care Director (RCD) and Resident Care Coordinator(s) (RCC) are to provide written acknowledgement after new admission to admitting staff member, representative of organization, and any additional pertinent staff members. In addition, The Charlotte MedTechs have been provided training on ordering medications through partnered pharmacy for medcations not on cart, noting communication of pharmacy contact and contacting pharmacy for clarification of orders; initial training sessions started on Jan. 26th 2026 concluding training sessions on topic for Feb. 16th 2026. Resident Care Director, Resident Care Coordinator(s), and/or Designee will continue to consult with Home Health service organizations and Hospice organizations on all change of condiditons, including order changes and Care Plan updates. Resident Care Director, Resident Care Coordinator(s), and/or Designee will audit at bi-weekly "At Risk" meetings. Interdisciplinary Team (IDT) will review data monthly during Quality Assurance and Performance Improvement (QAPI) meeting.	2.10.2026

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D 344	Continued From page 8 5mg, give one tablet by mouth every 4 hours as needed for pain/shortness of breath, with a start date of 12/19/25. Review of Resident #2's medication administration record (MAR) for January 2026 revealed: -There was an entry for oxycodone HCl 5mg, give one tablet by mouth every 4 hours as needed for pain/shortness of breath. -There was an entry for oxycodone HCl 5mg, give one tablet by mouth three times a day (6:00am,12:00pm, and 6:00pm) for pain and/or shortness of breath. Refer to the interview with the medication aide MA on 01/14/26 at 11:20am. Refer to the interview with the RCD on 01/14/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. Observation of Resident #2's medications available for administration on 01/13/26 revealed: -There was one medication card for oxycodone HCl 5mg, give one tablet by mouth every 4 hours as needed for pain/shortness of breath. -There was not a medication card for oxycodone HCl 5mg, give one tablet by mouth three times a day (6:00am,12:00pm, and 6:00pm) for pain and/or shortness of breath. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/14/26 at 2:55pm revealed: -Levsin .125mg, give one tablet by mouth every four hours as needed for pain/shortness of breath was profiled for Resident #2 on 12/19/25, and	D 344		

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D 344	Continued From page 9 was not dispensed to the facility because an order was not received. -Resident #2 had an order for levsin .125mg, give one tablet twice daily for shortness of breath, was received on 01/05/26 and 56 tablets were dispensed to the facility on 01/8/26. -Resident #2 had an order for oxycodone HCl 5mg tablets, give one tablet by mouth every 4 hours as needed for pain/shortness of breath, and 30 tablets were dispensed on 12/30/25. -Resident #2 had an order for oxycodone HCl 5mg tablets, give one tablet by mouth every 4 hours as needed for pain/shortness of breath, and 30 tablets were dispensed to the facility on 01/14/26. -The pharmacy did not receive an order for Resident #2 for oxycodone 5mg, give one tablet by mouth three times a day (6:00am,12:00pm, and 6:00pm) for pain and/or shortness of breath. Telephone interview with a hospice manager from the facility's contracted hospice provider on 01/15/26 at 5:12pm revealed: -Resident #2 was admitted to hospice services on 12/18/25 after a hospital discharge on 12/18/25. -Resident #2 was seen by hospice on 01/05/26 and an order dated 01/05/26 for oxycodone HCl 5mg, give one tablet by mouth three times a day (6:00am,12:00pm, and 6:00pm) for pain and/or shortness of breath, was given to the facility and not sent to the pharmacy. -She did not know the facility expected hospice to send medication orders/ changes to the pharmacy. -She did not know the facility entered the scheduled order for oxycodone HCl 5mg on the MAR and did not notify the pharmacy. -There was a breakdown in communication between hospice and the facility, related to sending medication orders to the pharmacy.	D 344		

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D 344	Continued From page 10 Interview with the MA on 01/14/26 at 11:20am revealed: -She did not know why Resident #2's scheduled levsin .125mg tablets and oxycodone 5mg tablets were not available. -She administered the scheduled levsin .125mg tablets and scheduled oxycodone 5mg tablets from the "as needed" medication cards. -She did not contact the pharmacy or notify the Resident Care Director that there was not a medication card available for levsin .125mg tablet and oxycodone 5mg tablets because she thought Resident #2's medications were on order and not yet received. Interview with the RCD on 01/15/26 at 1:46pm revealed: -The facility did not prefer to use "as needed" medications in place of scheduled medications. -Resident #2 should have had a medication card available for administration for the scheduled doses of levsin .125mg, give one tablet by mouth two times a day (6:00am and 6:00pm) for secretions and oxycodone HCl 5mg, give one tablet by mouth three times a day (6:00am,12:00pm, and 6:00pm) for pain and/or shortness of breath. -Resident #2's scheduled doses of levsin and oxycodone were not available on the cart because the hospice provider did not send the order changes to the pharmacy when the orders were written on 01/05/26. -She and the Resident Care Coordinator (RCC) were responsible for ensuring the pharmacy received changes in medication orders. -She expected the hospice provider who initiated the medication order, to send medication orders to the pharmacy.	D 344		

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(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 344	Continued From page 11 Interview with the Administrator on 01/15/26 at 2:53pm revealed: -MAs were responsible for contacting the pharmacy or notifying their supervisor if ordered medications were not available for administration. -She expected scheduled medications to be administered from appropriate medication cards and not from "as needed" medication cards. -She expected the hospice provider to send medication orders to the pharmacy in addition to providing the facility with a copy of the order. -The hospice provider was new to the facility and there may have been a communication issue related to the process for sending medication orders to the pharmacy.	D 344		
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, record review and interviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#2), related to oxygen. The findings are: Review of Resident #2's current FL2 dated	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060158	A. BUILDING: _____ B. WING _____	R-C 01/15/2026

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D 358	Continued From page 12 12/12/25 revealed: -Resident #2's diagnoses included pulmonary fibrosis, atrial fibrillation, congestive heart failure and hyperlipidemia. -There was an order for 4 liters of continuous oxygen via nasal cannula. -Resident #2 was ambulatory. -Resident #2's level of care was assisted living. Review of Resident #2's Resident Register revealed an admission date of 12/12/25. Review of hospice admission physician orders dated 12/18/25 revealed there was an order for 6 liters continuous oxygen via nasal cannula. Review of Resident #2's electronic medication administration record (eMAR) for December 2025 and January 2026 revealed an entry for 4 liters of continuous oxygen via nasal cannula. Observation of Resident #2 on 01/14/26 at 11:10am revealed he was using 5 liters of oxygen via nasal cannula. Interview with Resident #2 on 01/14/26 at 11:10am revealed: -His oxygen order was increased from 4 liters continuous via nasal cannula to 6 liters continuous in December 2025. -He was pleased with the current management of his care from hospice and his pulmonologist. Interview with a medication aide (MA) on 01/14/26 at 11:20am revealed: -Resident #2 had an order for 4 liters of continuous oxygen via nasal cannula. -She was aware Resident #2 increased his oxygen on his own, from 4 liters continuous to 6 liters continuous at times when he experienced	D 358		

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D 358	Continued From page 13 increased anxiety. -She usually returned Resident #2's oxygen back to 4 liters (per the order), when she checked on him or administered scheduled medications. -She informed the hospice nurse of Resident #2's behavior (increasing his own oxygen to 6 liters as needed). Telephone interview with a hospice nurse manager from the facility's contracted hospice provider on 01/15/26 at 5:12pm revealed: -Resident #2's oxygen order was increased to 6 liters continuous oxygen via nasal cannula when he was admitted to hospice care on 12/18/25. -She did not know why the facility did not have the correct order for Resident #2's oxygen. -She expected hospice orders to match the facility's orders. Interview with the Resident Care Director (RCD) on 01/15/26 at 1:46pm revealed: -She was responsible for ensuring medication orders from 3rd party providers matched the facility orders. -She was not aware Resident #2's oxygen was increased from 4 liters continuous to 6 liters continuous when he was admitted to hospice care on 12/18/26. -She expected the hospice provider to communicate changes in Resident #2's medication orders to the facility. Interview with the Administrator on 01/15/26 at 3:30pm revealed: -The clinical managers were responsible for managing any written orders in-house, including hospice orders. -The hospice provider did not notify the facility that Resident #2's oxygen order was increased	D 358		

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D 358	Continued From page 14 from 4 liters continuous to 6 liters continuous when he was admitted to hospice services on 12/18/25. -The hospice provider was new to the facility and may not have been familiar with the facility's process.	D 358	Referencing 10A NCAC 13F .1004(g) Medication Administration. Medication Administration course provided by Guardian Pharmacy (partnered pharmacy organization) on February 5th, 2026 to review medications administration standards of providing medications within one hour before or one hour after scheduled medication schedule timeline along with proper documentation of Medication Administration within the EMR system Point Click Care. Additional traning for MedTech's on processes of the organization, potential risks of late medication administration, and process on team member and/or supervisor to contact in the event administration timeline limit is near was conducted starting on Jan. 28th 2026, concluding on February 16th, 2026. Trainings included: medicaiton administration expectations, team member contact (SIC) when the risk of medication administration has the potential to reach outside of standardized timeline, not to be indicated in EMR, training on EMR system Point Click Care (PCC) on how to appropriately document all medication administration, and notifying clinical manager. Guardian Pharmacy (partnered pharmacy) providing Medication Care Audit of medictions on February 4th, 2026. Follow-up audits, by Guardian Pharmacy, completed monthly and as needed to ensure compliance. Resident Care Director, Resident Care Coordinator(s), and/or Designee to complete weekly audit on Medicaiton and Treatment Administration Schedules weekly. Interdisciplinary Team (IDT) will discuss findings monthly at Qaulity Assurance and Performance Improvement (QAPI) meeting.	2.10.2026
D 364	10A NCAC 13F .1004 (g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled times for 2 of 5 residents sampled (#1 and #3), resulting in medications ordered multiple times a day being administered too close to the next scheduled administration time and medications not being administered at consistent time intervals to ensure therapeutic effectiveness. The findings are: 1. Review of Resident #1's current FL2 dated 12/11/25 revealed: -Diagnoses included congestive heart failure, mild cognitive impairment, irritable bowel syndrome and ulcerative colitis. -There was an order for metoprolol ER (used to treat hypertension) 100mg, 0.5 tablet every morning. -There was an order for solifenacin succinate (used to treat urinary frequency) 10mg daily.	D 364		

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D 364	Continued From page 15 -There was an order for losartan potassium (used to treat an over active bladder) 10mg daily. -There was an order for cholestyramine (used to treat irritable bowel syndrome) oral packet 4gm mixed with 8oz fluid two times daily. -There was an order for balsalazide disodium (used to treat ulcerative colitis) 750mg three times daily. -There was an order for atorvastatin calcium (used to treat hypertension) 10mg daily. -There was an order for amlodipine besylate (used to treat hypertension) 5mg daily. Review of Resident #1's December 2025 Medication Administration Audit Report revealed: -On 12/22/25, the metoprolol was administered at 10:12am instead of within one hour before or after the scheduled 8:00am administration time. -On 12/22/25, the solifenacin was administered at 10:14am instead of within one hour before or after the scheduled 8:00am administration time. -On 12/22/25, the losartan was administered at 10:13am instead of within one hour before or after the scheduled 8:00am administration time. -On 12/22/25, the cholestyramine was administered at 10:16am instead of within one hour before or after the scheduled 8:00am administration time. -On 12/22/25, the balsalazide was administered at 10:12am instead of within one hour before or after the scheduled 8:00am administration time. -On 12/22/25, the atorvastatin was administered at 10:12am instead of within one hour before or after the scheduled 8:00am administration time. -On 12/22/25, the amlodipine was administered at 10:13am instead of within one hour before or after the scheduled 8:00am administration time. Interview with Resident #1's Nurse Practioner (NP) on 01/14/26 at 12:00pm revealed:	D 364		

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D 364	Continued From page 16 -On 12/22/25, he saw Resident #1 for an initial visit. -He reviewed all of Resident #1's medications, history, care plan and current concerns. -He expected the staff to administer medications within one hour before or after the the scheduled 8:00am administration time but did not have concerns related to Resident #1 receiving medications that morning outside the one hour before or after the scheduled 8:00am administration time. Refer to interview with a medication aide (MA) on 01/15/26 at 12:49pm. Refer to interview with the Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to interview with the Administrator on 01/15/26 at 2:53pm. 2. Review of Resident #3's current FL2 dated 12/01/25 revealed: -Diagnoses included major depressive disorder, hypertension, convulsions and gastro-esophageal reflux disease (GERD). -There was an order for rosuvastatin (a medication to treat high cholesterol levels) 10mg, one tablet daily. -There was an order for metoprolol (a medication to treat hypertension) 50mg, one tablet twice daily. -There was an order for ursodiol (a medication to dissolve gallstones) 300mg, one capsule three times daily. -There was an order for aspirin (a medication to treat pain and thin blood) 81mg, one tablet daily. -There was an order for carbamazepine (a medication to prevent seizures) 200mg, two tablets twice daily.	D 364		

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D 364	Continued From page 17 -There was an order for senna (a medication to treat constipation) 8.6mg, one tablet twice daily. -There was an order for levetiracetam (a medication to prevent seizures) 1000mg, one tablet twice daily. -There was an order for Myrbetriq (a medication to treat over-active bladder) 25mg, one tablet daily. -There was an order for docusate (a medication to treat constipation) 100mg, one capsule twice daily. -There was an order for vitamin B-12 (a vitamin to treat low B-12 levels) 1000mcg, one tablet daily. -There was an order for meloxicam (a medication to treat pain) 15mg, one tablet daily. Review of Resident #3's December 2025 Medication Administration Audit Report revealed: -On 12/22/25, rosuvastatin 10mg one tablet was administered at 10:23am instead of within one hour before or one hour after the scheduled 8:00am administration time. -On 12/22/25, metoprolol 50mg one tablet was administered at 10:22am instead of within one hour before or one hour after the scheduled 8:00am administration time. -On 12/22/25, ursodiol 300mg one tablet was administered at 10:22am instead of within one hour before or one hour after the scheduled 8:00am administration time. -On 12/22/25, aspirin 81mg one tablet was administered at 10:22am instead of within one hour before or one hour after the scheduled 8:00am administration time. -On 12/22/25, carbamazepine 200mg two tablets were administered at 10:22am instead of within one hour before or one hour after the scheduled 8:00am administration time. -On 12/22/25, senna 8.6mg one tablet was administered at 10:23am instead of within one	D 364		

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D 364	Continued From page 18 hour before or one hour after the scheduled 8:00am administration time. -On 12/22/25, levetiracetam 1000mg one tablet was administered at 10:22am instead of within one hour before or one hour after the scheduled 8:00am administration time. -On 12/22/25, Myrbetriq 25mg one tablet was administered at 10:22am instead of within one hour before or one hour after the scheduled 8:00am administration time. -On 12/22/25, docusate 100mg one tablet was administered at 10:22am instead of within one hour before or one hour after the scheduled 8:00am administration time. -On 12/22/25, vitamin B-12 1000mcg one tablet was administered at 10:22am instead of within one hour before or one hour after the scheduled 8:00am administration time. -On 12/22/25, meloxicam 15mg one tablet was administered at 10:22am instead of within one hour before or one hour after the scheduled 8:00am administration time. Interview with Resident #3's Nurse Practitioner (NP) on 01/14/26 at 12:30pm revealed: -He expected medication aides to administer medications within the one hour before or after the scheduled administration time. -He was not notified Resident #3's medications scheduled at 8:00am on 12/22/25 were administered late. Refer to interview with a medication aide (MA) on 01/15/26 at 12:49pm. Refer to interview with the Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to interview with the Administrator on 01/15/26 at 2:53pm.	D 364		

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D 364	Continued From page 19 Interview with a medication aide (MA) on 01/15/26 at 12:49pm revealed: -The MAs were responsible to administer resident medications within one hour before to one hour after the scheduled time. -There were times she had three medication carts and was required to administer medications to all the residents on those carts. -Residents' morning medications were often late if she was assigned three medication carts. -If she was behind, she could ask the MA Supervisor for help, but often the MA Supervisor had her own medication carts and was also passing resident medications. Interview with the Resident Care Director (RCD) on 01/15/26 at 1:46pm revealed: -The MAs were responsible to administer resident medications within one hour before to one hour after the scheduled time. -If a MA was running behind passing medications the MA could ask for help from another MA or ask her for help. -Residents did not consistently complain of late medications but that morning (01/15/26) she did have a resident inform her that her medications were administered late. -She did not review the Medication Administration Audit Report regularly unless residents complained of late administration of medications. Interview with the Administrator on 01/15/26 at 2:53pm revealed: -She expected the MAs to administer resident medications within the 2-hour range, from an hour before to an hour after the scheduled administration time. -If a MA administered medications late she	D 364		

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D 364	Continued From page 20 expected them to notify the MA Supervisor and to document why the medications were late.	D 364		
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, interviews and record reviews, the facility failed to ensure electronic Medication Administration Records (eMARs) were accurate for 2 of 5 sampled residents (#2 and #3) related to documentation of medications to treat blood clots, heart burn, secretions, pain or	D 367		

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D 367	Continued From page 21 shortness of breath, cough, wheezing, seizures, constipation, nerve pain, gallstones, high blood pressure, depression and enlarged prostate gland. The findings are: 1. Review of Resident #3's current FL2 dated 12/01/25 revealed diagnoses included major depressive disorder, hypertension, convulsions and gastro-esophageal reflux disease (GERD). a. Review of Resident #3's current FL2 dated 12/01/25 revealed there was an order for levetiracetam (a medication to treat seizures) 1000mg, one tablet twice daily. Review of Resident #3's December 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for levetiracetam 1000mg, one tablet twice daily scheduled at 8:00am and 8:00pm. -There was documentation levetiracetam 1000mg, one tablet was administered daily at 8:00am and 8:00pm except on 12/22/25 at 8:00pm with no explanation. Observation of medication on hand for Resident #3 on 01/14/26 at 4:18pm revealed there was a bubble pack of levetiracetam 1000mg containing 25 tablets. Interview with Resident #3's on 01/13/26 at 9:36am revealed he thought he received his medications as ordered. Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm.	D 367		

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D 367	Continued From page 22 Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. b. Review of Resident #3's current FL2 dated 12/01/25 revealed there was an order for docusate (a medication to treat constipation) 100mg, one capsule twice daily. Review of Resident #3's December 2025 eMAR revealed: -There was an entry for docusate 100mg, one tablet twice daily scheduled at 8:00am and 8:00pm. -There was documentation docusate 100mg, one tablet was administered daily at 8:00am and 8:00pm except on 12/22/25 at 8:00pm with no explanation. Observation of medication on hand for Resident #3 on 01/14/26 at 4:18pm revealed there were two bubble packs of docusate 100mg containing 53 tablets. Interview with Resident #3's on 01/13/26 at 9:36am revealed he thought he received his medications as ordered. Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. c. Review of Resident #3's current FL2 dated	D 367		

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D 367	Continued From page 23 12/01/25 revealed there was an order for gabapentin (a medication to treat nerve pain) 600mg, one tablet every six hours. Review of Resident #3's November 2025 eMAR revealed: -There was an entry for gabapentin 600mg, one tablet every six hours scheduled at 12:00am, 6:00am, 12:00pm and 6:00pm. -There was documentation gabapentin 600mg, one tablet was administered daily at 12:00am, 6:00am, 12:00pm and 6:00pm except at 6:00am on 11/03/25, 11/09/25 and 11/10/25 with no explanation. Review of Resident #3's December 2025 eMAR revealed: -There was an entry for gabapentin 600mg, one tablet every six hours scheduled at 12:00am, 6:00am, 12:00pm and 6:00pm. -There was documentation gabapentin 600mg, one tablet was administered daily at 12:00am, 6:00am, 12:00pm and 6:00pm except at 6:00am on 12/17/25, 12/22/25, 12/23/25 and at 12:00am on 12/23/25 with no explanation. Review of Resident #3's January 2026 eMAR revealed: -There was an entry for gabapentin 600mg, one tablet every six hours scheduled at 12:00am, 6:00am, 12:00pm and 6:00pm. -There was documentation gabapentin 600mg, one tablet was administered daily at 12:00am, 6:00am, 12:00pm and 6:00pm except at 6:00am 01/06/26 with no explanation. Observation of medication on hand for Resident #3 on 01/14/26 at 4:18pm revealed there was a bubble pack of gabapentin 600mg containing 23 tablets.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060158	A. BUILDING: _____ B. WING _____	R-C 01/15/2026

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

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D 367	Continued From page 24 Interview with Resident #3's on 01/13/26 at 9:36am revealed he thought he received his medications as ordered. Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. d. Review of Resident #3's current FL2 dated 12/01/25 revealed there was an order for ursodiol (a medication to dissolve gallstones) 300mg, one capsule three times daily. Review of Resident #3's December 2025 eMAR revealed: -There was an entry for ursodiol 300mg, one tablet three times daily scheduled at 8:00am, 4:00pm and 10:00pm. -There was documentation ursodiol 600mg, one tablet was administered daily at 8:00am, 4:00pm and 10:00pm except on 12/22/25 at 10:00pm with no explanation. Observation of medication on hand for Resident #3 on 01/14/26 at 4:18pm revealed there was a bubble pack of ursodiol 600mg containing 23 tablets. Interview with Resident #3's on 01/13/26 at 9:36am revealed he thought he received his medications as ordered. Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm.	D 367		

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D 367	Continued From page 25 Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. e. Review of Resident #3's current FL2 dated 12/01/25 revealed there was an order for carbamazepine (a medication to prevent seizures) 200mg, two tablets twice daily. Review of Resident #3's December 2025 eMAR revealed: -There was an entry for carbamazepine 200mg, two tablets twice daily scheduled at 8:00am and 8:00pm. -There was documentation carbamazepine 200mg, two tablets were administered daily at 8:00am and 8:00pm except on 12/22/25 at 8:00pm with no explanation. Observation of medication on hand for Resident #3 on 01/14/26 at 4:18pm revealed there was a bubble pack of carbamazepine 200mg containing 50 tablets. Interview with Resident #3's on 01/13/26 at 9:36am revealed he thought he received his medications as ordered. Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm.	D 367		

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D 367	Continued From page 26 f. Review of Resident #3's current FL2 dated 12/01/25 revealed there was an order for metoprolol (a medication to treat hypertension) 50mg, one tablet twice daily. Review of Resident #3's December 2025 eMAR revealed: -There was an entry for metoprolol 50mg, one tablet twice daily scheduled at 8:00am and 8:00pm. -There was documentation metoprolol 50mg, one tablet was administered daily at 8:00am and 8:00pm except on 12/22/25 at 8:00pm with no explanation. Observation of medication on hand for Resident #3 on 01/14/26 at 4:18pm revealed there was a bubble pack of metoprolol 50mg containing 25 tablets. Interview with Resident #3's on 01/13/26 at 9:36am revealed he thought he received his medications as ordered. Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. g. Review of Resident #3's current FL2 dated 12/01/25 revealed there was an order for senna (a medication to treat constipation) 8.6mg, one tablet twice daily. Review of Resident #3's December 2025 eMAR revealed:	D 367		

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D 367	Continued From page 27 -There was an entry for senna 8.6mg, one tablet twice daily scheduled at 8:00am and 8:00pm. -There was documentation senna 8.6mg, one tablet was administered daily at 8:00am and 8:00pm except on 12/22/25 at 8:00pm with no explanation. Observation of medication on hand for Resident #3 on 01/14/26 at 4:18pm revealed there was a bubble pack of senna 8.6mg containing 25 tablets. Interview with Resident #3's on 01/13/26 at 9:36am revealed he thought he received his medications as ordered. Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. h. Review of Resident #3's current FL2 dated 12/01/25 revealed there was an order for mirtazapine (a medication to treat depression) 7.5mg, one tablet at bedtime. Review of Resident #3's December 2025 eMAR revealed: -There was an entry for mirtazapine 7.5mg, one tablet at bedtime scheduled at 8:00pm. -There was documentation mirtazapine 7.5mg, one tablet was administered daily at 8:00pm except on 12/22/25 at 8:00pm with no explanation. Observation of medication on hand for Resident	D 367		

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D 367	Continued From page 28 #3 on 01/14/26 at 4:18pm revealed there was a bubble pack of mirtazapine 7.5mg containing 27 tablets. Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. i. Review of Resident #3's current FL2 dated 12/01/25 revealed there was an order for fluoxetine (a medication to treat depression)20mg, one capsule at bedtime. Review of Resident #3's December 2025 eMAR revealed: -There was an entry for fluoxetine 20mg, one capsule at bedtime scheduled at 8:00pm. -There was documentation fluoxetine 20mg, one capsule was administered daily at 8:00pm except on 12/22/25 at 8:00pm with no explanation. Observation of medication on hand for Resident #3 on 01/14/26 at 4:18pm revealed there was a bubble pack of fluoxetine 20mg containing 27 tablets. Interview with Resident #3's on 01/13/26 at 9:36am revealed he thought he received his medications as ordered. Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm.	D 367		

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D 367	Continued From page 29 Refer to the interview with the Administrator on 01/15/26 at 2:53pm. j. Review of Resident #3's current FL2 dated 12/01/25 revealed there was an order for tamsulosin (a medication to treat an enlarged prostate gland) 0.4mg, one capsule at bedtime. Review of Resident #3's December 2025 eMAR revealed: -There was an entry for tamsulosin 0.4mg, one capsule at bedtime scheduled at 8:00pm. -There was documentation tamsulosin 0.4mg, one capsule was administered daily at 8:00pm except on 12/22/25 at 8:00pm with no explanation. Observation of medication on hand for Resident #3 on 01/14/26 at 4:18pm revealed there was a bubble pack of tamsulosin 0.4mg containing 27 tablets. Interview with Resident #3's on 01/13/26 at 9:36am revealed he thought he received his medications as ordered. Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. 2. Review of Resident #2's current FL2 dated 12/12/25 revealed: -Resident #2's diagnoses included pulmonary fibrosis, atrial fibrillation, congestive heart failure	D 367		

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D 367	Continued From page 30 and hyperlipidemia. -There was an order for Pradaxa 150mg (used to treat blood clots), one capsule by mouth twice daily and omeprazole 20mg (used to treat heartburn), one tablet by mouth twice daily. -Resident #2 was ambulatory. -Resident #2's level of care was assisted living. Review of Resident #2's record revealed a hospice admission date of 12/18/25. a. Review of Resident #2's hospice physician orders dated 12/19/25 revealed there was an order for Pradaxa 75mg capsule, one capsule two times a day. Review of Resident #2's December 2025 e-MAR revealed: -There was an entry for Pradaxa 75mg, one capsule two times a day. -There was no documentation Pradaxa 75mg was administered on 12/16/25 (8:00pm) and 12/17/25 (8:00pm). Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. b. Review of Resident #2's hospice physician orders dated 12/19/25 revealed there was an order for omeprazole 20mg tablet extended release, one tablet two times a day. Review of Resident #2's December 2025 e-MAR revealed:	D 367		

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D 367	Continued From page 31 -There was an entry for omeprazole 20mg, one tablet two times a day. -There was no documentation omeprazole 20mg was administered on 12/16/25 (8:00pm) and 12/17/25 (8:00pm). Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. c. Review of Resident #2's hospice physician orders dated 01/05/26 revealed there was an order for levsin .125mg, take one tablet by mouth two times a day (6:00am and 6:00pm) for secretions. Review of Resident #2's e-MAR for January 2026 revealed: -There was an entry for levsin .125mg, take one tablet by mouth two times a day (6:00am and 6:00pm) for secretions. -There was no documentation levsin .125mg was administered to Resident #2 on 01/06/26 at 6:00am. Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. d. Review of Resident #2's hospice physician	D 367		

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D 367	Continued From page 32 orders dated 1/5/26 revealed there was an order oxycodone 5mg (used to treat pain/ shortness of breath) three times a day (6:00am, 12:00pm, and 6:00pm). Review of Resident #2's e-MAR for January 2026 revealed: -There was an order for oxycodone 5mg, take one tablet 3 times per day (6:00am, 12:00pm, and 6:00pm). -There was no documentation oxycodone 5mg was administered to Resident #2 on 01/06/26 at 6:00am. Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. e. Review of Resident #2's hospice physician orders dated 1/5/26 revealed there was an order for ipratropium .5mg-albuterol 3mg/ 3ml nebulization 3 times a day (6:00pm, 12:00pm, 6:00pm) for shortness of breath. Review of Resident #2's e-MAR for January 2026 revealed: -There was an order for ipratropium .5mg-albuterol 3mg/ 3ml nebulization 3 times a day (6:00pm, 12:00pm, 6:00pm) for shortness of breath. -There was no documentation ipratropium .5mg-albuterol 3mg/ 3ml nebulization was administered to Resident #2 on 01/06/26 at 6:00am.	D 367		

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D 367	Continued From page 33 Refer to the interview with a medication aide (MA) on 01/14/26 at 4:18pm. Refer to the interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm. Refer to the interview with the Administrator on 01/15/26 at 2:53pm. Interview with a medication aide (MA) on 01/14/26 at 4:18pm revealed: -She thought the blank holes on the eMAR were because there was no documentation the MA did or did not administer the medication at that time. -She sometimes held off documenting on the eMAR if a resident was out of the facility and not available to administer medications as they may return within the two-hour window, at which point she could administer the medications. -The MAs were responsible to document on the eMAR if a medication was or was not administered. Interview with Resident Care Director (RCD) on 01/15/26 at 1:46pm revealed: -The MAs were responsible to document on the eMAR if a residents' medication was or was not administered. -She did not know why there were blank documentation areas on the eMARs. -It was possible the blank documentation areas were because the MA failed to complete any documentation of that medication. -The previous Resident Care Coordinator (RCC) was responsible for completing daily audits of missed medications. -In mid-December she discovered the daily audits of missed medications were not being done and she began doing them daily.	D 367		

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D 367	Continued From page 34 Interview with the Administrator on 01/15/26 at 2:53pm revealed: -The MAs were responsible for documenting if medication was or was not given. -The eMAR system flagged any late medications with the color red. -The MAs were responsible for ensuring there were no flagged medications prior to leaving the building after their shift. -The RCD was responsible for running a daily medications audit report that should indicate any medications with no administration documentation.	D 367		