Facility: The Haven at Carolina Place
License Number: HAL-060-107
Survey Conducted: September 5- 6, 2018
Adult Care Home SOD Report dated and received September 24, 2018 via email
Plan of Correction

10A NCAC 13F .0902(b) Health Care – Tag D 273
Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to the Specific Residents Cited:
Resident #3 was not injured nor had any adverse effects as a result of this deficiency. Upon this deficiency being brought to our attention, the community immediately contacted the pharmacy, to get the medication needed.

B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:
The community initiated an in-service for med techs and LPN's regarding the importance of assuring medications are on hand accordingly. This is to include, but not limited to; insuring the community has hard scripts from physicians (as applicable), order medications from pharmacy – confirming receipt of order and delivery to community, checking for medications on hand, no expired meds and following up with any discrepancies – in the event the community shouldn't receive medications. Med Tech's/LPN's will notify their immediate supervisor of any concerns/issues.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:
The Resident Service Director/Designee will conduct monthly med tech meetings to discuss issues and provide re-training as needed. The Resident Service Director/Designee will conduct weekly med cart audits at scheduled intervals. Upon receiving new MARs and/or Orders, the Resident Service Director/LPN/ Designee will conduct a two-step check on new MARs/Orders, to insure all orders are clear and completed accordingly. Each designee will sign-off (2 signatures) the orders accordingly, for accuracy and clarify any discrepancies with physician, if needed. This will be continued going forward.

D. With Respect to How the Plan of Corrective Measures will be Monitored:
The Resident Service Director/Designee will conduct med cart audits for one week (5x) to insure that medications are on hand and administered correctly. The monitoring will continue as follows: 3x/ week for 4 weeks, then 1x/month for 3 months. Executive Director will review any medication errors with the Resident Service Director and monitor compliance on a monthly basis. The duration of this plan is approximately four months. This is in addition to weekly med cart audits conducted and documented by the LPN/Designee.

This plan is in effect and should be fully implemented no later than thirty (30) days upon submitting this Plan of Correction, November 12, 2018.

Attachment #1

10A NCAC 13F .0902(c)(3-4) Health Care – Tag D 276
Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to the Specific Residents Cited:
Resident #1 was not injured nor had any adverse effects as a result of this deficiency. Upon this deficiency being brought to our attention, the community contacted the resident's physician, to make him aware. There is/was no current order in place.

B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:
The community initiated an in-service for all med techs and LPN's regarding the importance of assuring all orders are transcribed to the MARs accordingly. Med Tech's/LPN's will notify their immediate supervisor when/if they have questions about an order and/or if there is conflicting information. The Resident Service Director/ LPN/ Designee will contact the physician for further clarification, in necessary.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:
The Resident Service Director/Designee will conduct monthly Med Tech/LPN meetings to discuss issues and provide re-training as needed. The Resident Service Director/Designee will conduct chart audits at scheduled intervals. Upon receiving new MARs and/or Orders, the Resident Service Director/LPN/ Designee will conduct a two-step check on new MARs/Orders, to insure all orders are clear, completed and transcribed accordingly. Each designee will sign-off (2 signatures) the orders accordingly, for accuracy and clarify any discrepancies with physician, if needed. This will be continued going forward.

D. With Respect to How the Plan of Corrective Measures will be Monitored:
The Resident Service Director/Designee will conduct chart audits for one week (5x) to insure all orders are transcribed correctly. The monitoring will continue as follows: 3x/ week for 4 weeks, then 1x/month for 3 months. The Executive Director will review any discrepancies with the Resident Service Director/Designee and monitor compliance on a monthly basis. The duration of this plan is approximately four months. This is in addition to routine monthly chart audit conducted and documented by the LPN/Designee.

This plan is in effect and should be fully implemented no later than thirty (30) days upon submitting this Plan of Correction, November 12, 2018.

10/12/18

Attachment #2

10A NCAC 13F .1004(a) Medication Administration – Tag D 358

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to the Specific Residents Cited:
Resident #1 and #2 were not injured nor had any adverse effects as a result of this deficiency. Upon this deficiency being brought to our attention, the community contacted each resident's physician. For each resident, we received new orders and/or obtained clarification of, to include addressing the pharmacy "billing issue". Each is properly corrected.

B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:
The community initiated an in-service for med techs and LPN's regarding the importance of assuring medications are on hand accordingly. This is to include, but not limited to; insuring the community has hard scripts from physicians (as applicable), order medications from pharmacy – confirming receipt of order and delivery to community, checking for medications on hand, no expired meds and following up with any discrepancies – in the event the community shouldn't receive medications. Med Tech's/LPN's will notify their immediate supervisor of any concerns/issues. Thereafter, the Resident Service Director/Designee will clarify any issues with the pharmacy/physician, as applicable.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:
The Resident Service Director/Designee will conduct monthly med tech meetings to discuss issues and provide re-training as needed. Upon receiving new orders, the Resident Service Director/LPN/Designee will verify orders are correct, to include but not limited to; insuring parameters are correct, medications are on hand and addressing any pharmacy issues that require quick resolution – to guarantee medications are on hand when needed, per physician order.

D. With Respect to How the Plan of Corrective Measures will be Monitored:
The Resident Service Director/LPN/Designee will conduct random audits of MARs, at the beginning of each month. Further, random audits will be conducted at least 1x/week going forward. This audit will be for checking any new orders transcribed into the MARs accordingly. Sample size will be at least five (5) different charts each audit. Executive Director will review any discrepancies with the Resident Service Director/LPN/Designee and monitor compliance on a monthly basis.

This plan is in effect and should be fully implemented no later than thirty (30) days upon submitting this Plan of Correction, November 12, 2018.

11/12/18

Attachment #3

10A NCAC 13F .1004(j) Medication Administration – Tag D367

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to the Specific Residents Cited:
Resident #2 was not injured nor had any adverse effects as a result of this deficiency. Upon this deficiency being brought to our attention, the community contacted the resident's physician. We received new orders and/or obtained clarification of.

B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action:
The community initiated an in-service for med techs and LPN's regarding the importance of assuring medications are administered accordingly, documented as such, insuring there are no holes in the MARs. Med Tech's/LPN's will notify their immediate supervisor of any concerns/issues. Thereafter, the Resident Service Director/Designee will clarify any issues with the pharmacy/physician, as applicable.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:
The Resident Service Director/Designee will conduct monthly med tech meetings to discuss issues and provide re-training as needed. Upon receiving new orders, the Resident Service Director/LPN/Designee will verify orders are correct, to include but not limited to; insuring parameters are correct and transcribed into the MARs accordingly.

D. With Respect to How the Plan of Corrective Measures will be Monitored:
The Resident Service Director/LPN/Designee will conduct random audits of MARs, at the beginning of each month. Further, random audits will be conducted at least 1x/week going forward. This audit will be for checking any new orders transcribed into the MARs accordingly. Sample size will be at least five (5) different charts each audit. Executive Director will review any discrepancies with the Resident Service Director/LPN/Designee and monitor compliance on a monthly basis.

This plan is in effect and should be fully implemented no later than thirty (30) days upon submitting this Plan of Correction, November 12, 2018.

10/14/18

#4

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
	HAL060107	A. BUILDING: _____ B. WING _____	09/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN IN THE VILLAGE AT CAROLINA PLACE	13150 DORMAN ROAD PINEVILLE, NC 28134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 09/05/18 and 09/06/18 with an exit conference via telephone on 09/07/18.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care ~~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. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to notify the physician for 1 of 5 sampled residents did not have an anti-seizure medication available for administration (Resident #3). The findings are: 1. Review of Resident #3's current FL2 dated 06/12/18 revealed: -Diagnoses included dementia and hypertension. -A physician's order for diazepam 10mg (a benzodiazepine used for a seizure to promote a calming effect) per rectal (PR) suppository every 6 hours as needed (PRN). Review of Resident #3's record revealed: -There was an emergency room (ER) visit dated 04/17/18 diagnoses "seizures". -There was documentation Resident #3 had a seizure on 04/17/18 at 5:45am which lasted "about 2 minutes." -There was documentation the physician and the family were notified.	D 273	See Attachment #1	11/12/18

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jason T. Tucker — TITLE: Administrator — (X6) DATE: 10/12/18

Reviewed and acknowledged 10/15/18 jeanne s robinson RN

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D 273	Continued From page 1 -There was documentation dated 04/17/18 at 8:54am Resident #3 had another seizure which lasted "about 5 minutes." -The physician was notified and an order was obtained to send Resident #3 to the ER. -There was documentation Resident #3 had returned to the facility on 04/17/18 with no "new orders". Review of Resident #3's signed physician order dated 05/29/18 for diazepam 10mg PR every 6 hours for breakthrough seizures, inform the physician/on call after medicine is administered. Review of the Medication Administration Record (MAR) for the months of May 2018, June 2018, July 2018, August 2018 and September 2018 revealed: -There was an entry for diastat (diazepam) 10mg PR every 6 hours PRN for breakthrough seizures, inform the physician/on call after medicine is administered. -There was no documentation the diastat 10mg PR had been administered in May 2018, June 2018, July 2018, August 2018 or in September 2018. Observation on 09/05/18 at 2:20pm of medications on hand for Resident #3 revealed there were no diazepam 10mg PR on the medication cart. Interview with a medication aide (MA) on 09/05/18 at 2:20pm revealed: -The diazepam was not on the cart due to "the pharmacy was out of stock and insurance would not pay." -"Guess we need to get the doctor to change the order." -She had never contacted the pharmacy or the	D 273		

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D 273	Continued From page 2 physician in regard to the diazepam 10mg PR not being available for administration for Resident #3. -She knew Resident #3 had a seizure in April 2018. -"She [Resident #3] has not had another seizure since her last one." Telephone interview with a representative from the contracted pharmacy on 09/05/18 at 2:35pm revealed: -The pharmacy had received an order dated 05/29/18 for Resident #3 diazepam 10mg PR every 6 hours for breakthrough seizures, inform the physician/on call after medicine is administered. -The diazepam 10mg was never filled because "we do not have a hard script for the narcotic." -The facility had never contacted the pharmacy about the order for the diazepam 10mg for Resident #3. -To her knowledge the facility had never attempted to obtain the hard prescription from the physician so the diazepam 10mg could be filled for Resident #3. -The pharmacy had received additional orders dated 06/12/18 from the FL2 and signed physician orders dated 08/23/18 for the diazepam 10mg but not a hard prescription. -"It is the facility's responsibility to contact the physician to obtain a hard prescription for all narcotics, we cannot fill if we do not have this." Interview with a Licensed Practical Nurse (LPN) on 09/06/18 at 7:35am revealed: -The LPN's were responsible for all new physician orders. -The order was to be faxed to the pharmacy and "we obtain confirmation". -The new order was to be transcribed on to the MAR with 2 LPN's or a MA verifying the correct	D 273		

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D 273	Continued From page 3 ordered was transcribed. -A copy of the new order and the fax confirmation were to be filed in a "new order book" which was located in the medication room. -If the new medication did not come in via the pharmacy carrier on the night shift the staff are to contact the pharmacy and the physician if needed. -If medications were available they were to contact the physician for additional orders. -The Special Care Unit Coordinator (SCUC) was responsible for reviewing all new orders. -The SCUC was responsible for overseeing all the LPNs and MAs. Interview with a MA on 09/06/18 at 7:45am revealed: -The LPNs were responsible for faxing new physician orders to the pharmacy and transcribing them on the MAR. -The SCUC sometimes "handles the new orders." -The LPN or the SCUC were responsible for contacting the physician and the family. -The MAs can re-order medications from the pharmacy if resident's medication were low on the medication carts. -If the medication did not come in on the night drop they were to notify the LPNs or the SCUC know. Interview with the SCUC on 09/06/18 at 3:30pm revealed: -She did not know the diazepam 10mg for Resident #3 was not on the cart for administration. -The LPNs were responsible for processing all new orders. -If the medications were not available for administration the LPNs are responsible for contacting the physician.	D 273		

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D 273	Continued From page 4 -The medication cart audits were completed weekly to look for outdated medications and to assure all resident's medications were on hand for administration. -If a medication did not come in from the pharmacy on the "night run" the LPN was to contact the pharmacy and find out why it was not in the building. -She had not contacted the physician in regard to Resident #3's diazepam 10mg PR not being available. Interview with a night shift LPN on 09/06/18 at 3:38pm revealed: -She had worked night shift and first shift at times. -Medication cart audits were to be completed on night shift weekly and documented in a weekly cart audit book. -She could not recall the last time she had completed a medication cart audit. -She did not know why Resident #3's diazepam was not in the medication cart for administration. Review of the facility "Weekly Med Cart Audit" book revealed there was documentation medication cart audits were completed on 03/18/18; there was no other documentation on the weekly cart audit form. Telephone interview with Resident #3's physician's Registered Nurse on 09/05/18 at 3:00pm and on 09/06/18 at 8:05am revealed: -The physician did not know the diazepam 10mg PR was not in the facility for administration. -He expected the facility to follow his orders and to have the medication in the facility for administration if Resident #3 had needed it. -The physician ordered the diazepam to prevent Resident #3 from going to the ER if seizure	D 273		

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D 273	Continued From page 5 activity occurred. -The physician contacted the family on 05/29/18 and they were in agreement to use the diazepam for seizure activity to help prevent Resident #3 from having a seizure and having to be sent to the hospital. -The facility had not communicated with the office or the physician in regard to Resident #3's diazepam 10mg PR not being in the facility for administration if needed . -"If the facility does not tell the physician there is an issue with medications he does not know." Interview with the Resident Service Director (RSD) on 09/06/18 at 10:38am revealed: -The LPNs were responsible for faxing new orders to the pharmacy and receiving conformation. -The LPNs were responsible for transcribing the new orders on the MAR and getting a second LPN to verify the order. -The LPNs were to place a copy of the new order in the hot box for the SCUC to review. -The LPNs who worked night shift should check the night drop pharmacy medications to verify all new ordered medications were in the facility. -If the new medications are not in the facility they are to call the pharmacy and find out why. -They were to call the physician if there are any issues regarding medications. -She did not know Resident #3's diazepam 10mg was not on the medication cart for administration. -She relied on the LPN to follow all physicians' orders and to contact the physician if medications were not available for administration. Telephone interview with a family member for Resident #3 on 09/05/18 at 11:15am revealed: -He knew resident #3 had two seizures in April 2018.	D 273		

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D 273	Continued From page 6 -Resident #3 had one other episode of seizure activity in 2017. -The ER doctor had explained Resident #3 was maybe dehydrated or possibly had a urinary tract infection. -He knew the diazepam 10mg was ordered if Resident #3 had another seizure. -The family did not want Resident #3 to have another seizures if the facility could assist her by using the diazepam. Telephone interview with the Executive Director on 09/06/18 at 5:30pm revealed: -He did not know the diazepam 10mg ordered on 05/29/18 for Resident #3's seizures was not in the facility. -He relied on the LPNs and the SCUC to complete new orders and to follow physician orders as they were written. -He expected the LPNs to contact the physicians' office for follow-up for all new orders and medications.	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:	D 276	See Attachment T 10/12/18 10/12/18	11/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 276	Continued From page 7 Based on observations, interviews, and record reviews, the facility failed to implement physicians' orders for 1 of 5 sampled residents regarding daily blood pressure checks (Resident #1). The findings are: Review of Resident #1's current FL2 dated 08/27/18 revealed: -Diagnoses included transient ischemic attack, hypertension, dementia, hypothyroidism, hyperlipidemia, acute pain due to trauma. -There was an order to check blood pressure (BP) daily. Review of Resident #1's Resident Register revealed he was admitted on 08/28/18. Review of Resident #1's August and September 2018 Medication Administration Record (MAR) revealed: -There was no entry to check BP every day. -There were no daily BP's recorded. Interview with a first shift Licensed Practical Nurse (LPN) on 09/06/18 at 10:02am revealed: -She did not know Resident #1 had an order for BPs to be checked daily. -LPNs were responsible for recording the order for BP checks on the MAR. -LPNs were responsible for completing the MAR for new admissions, "I'm not sure why it was not listed". -BPs were recorded on a vital sign form once they were taken by a medication aide (MA) or LPN. -She had not taken or recorded Resident #1's daily blood pressure because it was not listed on the MAR.	D 276		

10/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 276	Continued From page 8 Interview with a secon shift LPN on 09/06/18 at 2:57pm revealed: -She did not know Resident #1 had an order for BPs to be checked daily. -She had not checked Resident #1's BP daily. -She had not noticed the order on the FL2. -She did not know why the daily BP checks were not listed on the MAR to complete daily. Further review of Resident #1's record revealed there was no vital signs form completed with daily BPs from 08/28/18-09/06/18. Interview with the Special Care Unit Coordinator (SCUC) on 09/06/18 at 11:28am revealed: -LPNs and MAs were responsible for recording treatment orders on the MAR. -Another LPN or MA was supposed to check behind the LPN/MA who transcribed on the MAR to ensure accuracy. -She did not know Resident #1 had an order for daily BP checks, "it was missed". -She expected LPNs and MAs to follow orders as written on the FL2 until physician discontinues the order. Interview with the Resident Services Director (RSD) on 09/06/18 at 12:10pm revealed: -She did not know Resident #1 had an order for daily BP checks. -She expected LPNs and MAs to transcribe treatment orders on the MAR. -She expected LPNs and MAs to follow orders and the contact physician if the order could not be followed. -LPNs and MAs are responsible for obtaining the BPs and recording the results on the vital signs form when there was an order. -She did not know how the order for BP checks	D 276		

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THE HAVEN IN THE VILLAGE AT CAROLINA PLACE	13150 DORMAN ROAD PINEVILLE, NC 28134

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D 276	Continued From page 9 was missed. Interview with Resident #1's physician's Registered Nurse (RN) on 09/06/18 at 1:36pm revealed: -The order for daily BP checks was written by previous physician. -The physician's first visit with Resident #1 was on 09/04/18. -He expected previous physician's orders to be followed until he was able to obtain previous medical records. -He had not discontinued the order for daily BP checks. -He expected the facility to follow the orders as written on the FL2. Interview with the Administrator on 09/07/18 at 9:07am revealed: -He did not know LPNs/MAs were not following physician orders to check Resident #1's BP daily. -He expected the MAs to follow all physician orders. -He expected the LPNs and MAs to check behind each other to make sure orders were not missed. Based on observation and record review, Resident #1 was not interviewable.	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	D 358	See Attachment #3	11/1/18

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	HAL060107	A. BUILDING: _____ B. WING _____	09/07/2018

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D 358	Continued From page 10 (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 assure 2 of 5 residents were administered medications as ordered by the licensed prescribing practitioners, mirtazapine for depression (Resident #1) and Humalog sliding scale insulin for control of high blood sugar (Resident #2) . The findings are: Review of Resident #2's current FL2 dated 05/08/18 revealed: -Diagnoses included diabetes mellitus II and dementia. -The physician orders included Lantus insulin 100 units/ml, inject 12 units in the morning; Humalog insulin 100units/ml, inject 12 units for finger stick blood sugar (FSBS) greater than 200mg/dl and FSBS checks three times a day before meals, at 7:30am, 11:30am and 4:30pm. Review of Resident #2's subsequent physician's order dated 07/20/18 revealed: -There was an order for Novolg 100units/ml vial to be administered per sliding scale instructions. -The sliding scale insulin (SSI) instructions were: for FSBS of 200-225mg/dl, administer 5 units of insulin; for FSBS of 226-250mg/dl, administer 8 units of insulin; for FSBS of 251-300mg/dl, administer 11 units of insulin; for FSBS of 301-350mg/dl, administer 14 units of insulin; for FSBS above 351mg/dl, administer 17 units of insulin. -No insulin was to be administered to the resident	D 358		

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D 358	Continued From page 11 if the FSBS was less than 200mg/dl. -There was an order to check the FSBS before each meal. Review of Resident #2's Medication Administration Record (MAR) for July 2018 revealed: -There was an entry for a FSBS to be checked at 7:30am, 11:30am and 4:30pm. -There was an entry for SSI with parameters as follows: a FSBS of 200-225mg/dl, administer 5 units of insulin; for a FSBS of 226-250mg/dl, administer 8 units of insulin; for a FSBS of 251-300mg/dl, administer 11 units of insulin; for a FSBS of 301-350mg/dl, administer 14 units of insulin; for a FSBS above 351mg/dl, administer 17 units of insulin. -There was an entry on 07/25/18 at 11:00am for a FSBS of 340mg/dl, 8 units of insulin were documented as administered, and 14 units of insulin should have been administered. -There was an entry on 07/26/18 at 11:00am for a FSBS of 418mg/dl, 14 units of insulin were documented as administered, and 17 units of insulin should have been administered. -There was an entry on 07/29/18 at 11:00am for a FSBS of 310mg/dl, 8 units of insulin were documented as administered, and 14 units of insulin should have been administered. Review of Resident #2's MAR for August 2018 revealed: -There was an entry for FSBS to be checked at 7:30am, 11:30am ad 4:30 pm. -There was an entry for SSI with parameters as follows:FSBS of 200-225mg/dl, administer 5 units of insulin; for FSBS of 226-250mg/dl, administer 8 units of insulin; for FSBS of 251-300mg/dl, administer 11 units of insulin; for FSBS of 301-350mg/dl, administer 14 units of insulin; for	D 358		

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D 358	Continued From page 12 FSBS above 351mg/dl, administer 17 units of insulin. -There was an entry on 08/01/18 at 7:30am for FSBS of 284mg/dl, 17 units of insulin were documented as administered, and 11 units of insulin should have been administered. -There was an entry on 08/05/18 at 4:30pm for FSBS of 269mg/dl, 17 units of insulin were documented as administered, and 11 units of insulin should have been administered. -There was an entry on 08/07/18 at 7:30 am for FSBS of 357mg/dl, 11 units of insulin were documented as administered, and 17 units of insulin should have been administered. -There was an entry on 08/10/18 at 7:30am for FSBS of 248mg/dl,14 units of insulin were documented as administered and 8 units of insulin should have been administered. -There was an entry on 08/13/18 at 4:30pm for FSBS of 104mg/dl, 5 units of insulin were documented as administered, and no insulin should have been administered. -There was an entry on 08/20/18 at 4:30pm for FSBS of 194mg/dl and 5 units of insulin were documented as administered, and no insulin should have been administered. -There was an entry on 08/27/18 at 4:30pm for FSBS of 193mg/dl, 5 units of insulin were documented as administered, and no insulin should have been administered. -There was an entry on 08/28/18 at 11:30am for FSBS of 156mg/dl, 5 units of insulin were documented as administered, and no insulin should have been administered... Review of Resident #2's MAR for September 2018 revealed: -There was an entry for a FSBS to be checked at 7:30am, 11:30am ad 4:30 pm. -There was an entry for SSI with parameters as	D 358		

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D 358	Continued From page 13 follows: for a FSBS of 200-225mg/dl, administer 5 units of insulin; for a FSBS of 226-250mg/dl, administer 8 units of insulin; for a FSBS of 251-300mg/dl, administer 11 units of insulin; for a FSBS of 301-350mg/dl, administer 14 units of insulin; for a FSBS above 351mg/dl, administer 17 units of insulin. -There was an entry on 09/02/18 for a FSBS of 286mg/dl, 8 units of insulin were documented as administered and 11 units of insulin should have been administered. -There was an entry on 09/04/18 for a FSBS of 282mg/dl, 2 units of insulin were documented as administered and 11 units of insulin should have been administered. Review of Resident #2's MARs from July 2018-September 2018 revealed the documented administration of the Novolog sliding scale for Resident #2 did not correspond to the physicians orders of 07/20/18 on 14 occasions. Interview with the medication aide on 09/05/18 at 2:43pm revealed: -There was only one resident with SSI at the time. -The MAR page for the documentation of the SSI administration was kept in a binder in the clinic office. -The sliding scale parameters were listed on the MAR. -The nurses administered the insulin to the residents. Interview with the first shift Licensed Practical Nurse (LPN) on 09/05/18 at 3:10pm revealed: -She administered the insulin, per the sliding scale orders, to Resident #2 on day shift. -She would take the Insulin Binder from the clinic to the medication cart and document when she administered the insulin on the MAR.	D 358		

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D 358	Continued From page 14 -She referred to the sliding scale parameters on the MAR after checking Resident #2's FSBS. -She did not know why she had documented the incorrect insulin dosage based on the FSBS reading. -She thought she gave him the correct insulin, but did not know why there was an incorrect dosage entered on the MAR. Telephone interview with the second shift LPN on 09/06/18 at 11:15am revealed: -She administered the insulin, per sliding scale orders, to Resident #2 on second shift. -The MAR for insulin documentation was kept in a binder in the clinic office. -She removed the MAR document from the binder and brought it to her medication cart to document. -She knew the sliding scale parameters were written on the MAR. -"There is not much room to enter the information on a paper MAR" (leaving it open to error in documentation). -She always checked the sliding scale parameters before administering insulin. -She did not know why she entered the insulin as administered incorrectly. -Interview with the Special Care Unit Coordinator (SCUC) on 09/06/18 at 3:20pm revealed: -The LPNs were responsible for checking the FSBS and administering insulin to the residents. -Resident #2 was the only resident who received SSI. -The Insulin Binder was kept in the Clinic for the LPNs to access and document when administering insulin and recording FSBS. -She thought the nurses removed the insulin binder, or the MARS from the binder, from the Clinic Office to the medication cart when	D 358		

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D 358	Continued From page 15 administering insulin to the residents. -The third shift LPN was responsible for checking the documentation in the MARs since she had more available time during the night shift.. -She was the supervisor of the LPNs and CNAs. -She had not been reviewing the Insulin Binder. -She thought it was the responsibility of the LPNs to administer the correct insulin dosage to the resident based on the sliding scale parameters. "That was why we have hired LPNs to administer the insulin." -She did not know the incorrect dosage of insulin was administered to Resident #2 on 14 occasions. Interview with the Resident Service Director (RSD) on 09/06/18 at 3:40pm revealed: -The SCUC was responsible for the Special Care Unit (SCU). -The SCUC oversees the clinical aspect of the SCU. -She did not know Resident #2 had received the incorrect dosage of insulin, based on the sliding scale parameters, on 14 occasions. Attempted phone interview with Resident #2's primary care physician on 09/06/18 at 1:05pm was unsuccessful. Telephone interview with the Executive Director on 09/07/18 at 9:01am revealed: -The SCUC was the clinical supervisor of the SCU. -The SCUC was an LPN and hired LPNs to administer medications and additional clinical duties. -The LPNs were to administer the insulin to the diabetic residents as ordered by the prescribing physician. -He did not know Resident #2 had been	D 358		

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D 358	Continued From page 16 administered the incorrect dosage of insulin 14 times between July 2018 and September 2018. -He expected the LPNs to administer insulin according to the orders from the prescribing physicians. -He expected the LPNs to provide accurate documentation of the medications they administered. 2. Review of Resident #1's current FL2 dated 08/27/18 revealed: Diagnoses included transient ischemic attack, hypertension, dementia, hypothyroidism, hyperlipidemia, acute pain due to trauma. -There was an order for mirtazapine (used to treat depression) 15mg 1 tablet daily. Review of Resident #1's Resident Register revealed he was admitted on 08/28/18. Observation of Resident #1's medications available for administration on 09/05/18 at 4:05pm revealed there was no mirtazapine 15mg on hand for administration. Review of Resident #1's August 2018 Medication Administration Record (MAR) revealed: -An entry for mirtazapine 15mg 1 tablet daily for depression scheduled at 8:00pm. -The mirtazapine was documented as administered 3 occurrences out of 3 opportunities from 08/29/18-08/31/18. Review of Resident #1's September 2018 MAR revealed: -An entry for mirtazapine 15 mg 1 tablet daily for depression scheduled at 8:00pm. -The mirtazapine was documented as administered 3 occurrences out of 4 opportunities from 09/01/18-09/04/18.	D 358		

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D 358	Continued From page 17 -On 09/04/18, the mirtazapine was documented as not administered with no reason listed. Interview with the second shift Licensed Practical Nurse (LPN) on 9/5/18 at 4:05pm revealed: -She did not know why the mirtazapine 15 mg was not available for Resident #1. -She checked the pharmacy communication book and no refill was requested. -MAs and LPNs were to fax refill requests and place them in the pharmacy communication book, "the request is not in the book". -LPNs and MAs could also call the pharmacy to request medications and "the medication is usually delivered the same night" -"I will call the pharmacy to order the medication". Telephone interview with a pharmacy technician from the facility's primary pharmacy for Resident #1 on 09/05/18 at 4:22pm revealed: -There was a 3 day supply of mirtazapine 15mg delivered to the facility on 08/28/18 as an "emergency supply". -"We are not the primary pharmacy, therefore we sent an emergency supply" -There were no requests since 08/28/18 to send additional mirtazapine 15mg tablets for Resident #1. Telephone interview with a pharmacy technician from the facility's primary pharmacy for Resident #1 on 09/06/18 at 11:43am revealed: -The order for mirtazapine 15mg was received on 08/28/18. -The mirtazapine was not filled for a 30 day supply because the medication had been ordered too early and insurance would not pay. -A 3 day emergency supply was sent on 09/05/18 as requested by the facility.	D 358		

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D 358	Continued From page 18 Interview with Resident #1's responsible party (RP) on 09/06/18 at 9:26am revealed: -He did not bring any medications into the facility with Resident #1 when he was admitted on 08/28/18. -Resident #1 had used another pharmacy prior to being admitted, but had not received any medication from the other pharmacy. -He signed a consent for all medications to be provided by the contracted pharmacy on 08/28/18. -He had not been notified of Resident #1 missing any of his medications. Observation of Resident #1's medications available for administration on 09/06/18 at 11:05am revealed there were 3 mirtazapine 15mg tablets on hand for administration supplied by the contracted pharmacy. Interview with a second shift LPN 09/06/18 at 2:57pm revealed: -She was the LPN who passed medications to Resident #1 on 09/01/18 and 09/02/18. -She could not remember if she gave Resident #1 his mirtazapine, "it is too many residents to remember". -She could not remember if the mirtazapine was available for administration. - "I recall a conversation with someone about a medication not being available and the pharmacy being contacted, but I can't remember everything". -She could not remember contacting the pharmacy regarding Resident #1's mirtazapine. Interview with another second shift LPN on 09/06/18 at 2:37pm revealed: -She was the LPN who passed medications to Resident #1 on 09/03/18.	D 358		

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D 358	Continued From page 19 -She did not remember the mirtazapine 15mg being available for administration. -She did not administer mirtazapine 15mg to Resident #1. -She thought the mirtazapine was on order for Resident #1, but she stated "I cannot remember". -She forgot to circle her initials and document on the back of the MAR that the medication was not available. -She could not remember if she contacted the pharmacy to order the mirtazapine for Resident #1. Telephone interview with Resident #3's primary care provider's Registered Nurse (RN) on 09/06/18 at 10:59am and 1:36pm revealed: -The physician did not initially prescribe the mirtazapine for Resident #1. -Resident #1 was prescribed the mirtazapine from the previous physician at another facility. -He expected orders from previous physician to be followed until he discontinued them. -He saw Resident #1 on 09/04/18 and he had not discontinued any medications. -If Resident #1 was to miss 1 or more doses of mirtazapine "he could be more depressed and his sleep could be interrupted". Telephone interview with the Special Care Unit Coordinator (SCUC) on 09/06/18 at 11:28am revealed: -She did not know Resident #1's mirtazapine had not been filled by the facility for a 30 day supply. -She expected the LPNs and MAs to contact the pharmacy if medication was not available to administer. -The facility will pay for the medication if there were billing issues. -"Resident #1 should not have went without any of his medications".	D 358		

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D 358	Continued From page 20 Interview with the Resident Services Director (RSD) on 09/06/18 at 12:10pm revealed: -She expected all residents to receive medications as ordered by the physician. -She did not know about any billing issues that prevented Resident #1 from receiving his mirtazapine. -If medication was not available, she expected LPNs and MAs to contact the pharmacy to determine the status and obtain the medications. -"We have told the pharmacy in the past, to bill us if there are billing issues". Telephone interview with the Administrator on 09/0718 at 9:07am revealed: -He expected LPNs and MAs to administer medications as ordered. -He expected LPNs and MAs to contact the pharmacy if medication was not available to determine the status. -LPNs and MAs should also notify RSD and SCUC if there are issues getting medications. -"We will pay for medications if there are billing issues with the pharmacy". Based on observation and record review, Resident #1 was not interviewable.	D 358		
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	D 367	See Attachment # 4	11/12/18

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D 367	Continued From page 21 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 record reviews and interviews, the facility failed to assure the accuracy of the Medication Administration Record (MAR) for 1 of 5 sampled residents (Resident #2) related to documenting the administration of Novolog insulin, a medication used to control high levels of sugar in the bloodstream. The findings are: Review of Resident #2's FL2 dated 05/08/18 revealed: -Diagnoses included diabetes mellitus II and dementia. -The physician orders included Lantus insulin 100units/ml, inject 12 units in the morning; Humalog insulin100units/ml, inject 12 units for finger stick blood sugar (FSBS) greater than 200mg/dl and FSBS checks three times a day before meals, at 7:30am, 11:30am and 4:30pm. Review of Resident #2's subsequent physician's	D 367		

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D 367	Continued From page 22 order dated 07/20/18 revealed: -An order for Novolog 100units/ml vial to be administered per sliding scale instructions. -The sliding scale insulin (SSI) instructions were: for a FSBS of 200-225mg/dl, administer 5 units of insulin; for a FSBS of 226-250mg/dl, administer 8 units of insulin; for a FSBS of 251-300mg/dl, administer 11 units of insulin; for a FSBS of 301-350mg/dl, administer 14 units of insulin; for a FSBS above 351mg/dl, administer 17 units of insulin. -The was an order order to check the FSBS before each meal. Review of Resident #2's MAR for July 2018 revealed: -There was an entry for the FSBS to be checked at 7:30am, 11:30am ad 4:30 pm. -There was an entry for SSI with parameters as follows: for a FSBS of 200-225mg/dl, administer 5 units of insulin; for a FSBS of 226-250mg/dl, administer 8 units of insulin; for a FSBS of 251-300mg/dl, administer 11 units of insulin; for a FSBS of 301-350mg/dl, administer 14 units of insulin; for a FSBS above 351mg/dl, administer 17 units of insulin. -On 07/22/18 at 4:30pm there was no documentation the Novolog insulin was administered to Resident #2 for a FSBS of 294mg/dl. -On 07/23/18 at 4:30pm there was no documentation the Novolog insulin was administered to Resident #2 for a FSBS of 236mg/dl. -On 07/24/18 at 4:30pm there was no documentation the Novolog insulin was administered to Resident #2 for a FSBS of 390mg/dl. -On 07/25/18 at 4:30pm there was no documentation the Novolog insulin was	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060107	A. BUILDING: _____ B. WING _____	09/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN IN THE VILLAGE AT CAROLINA PLACE	13150 DORMAN ROAD PINEVILLE, NC 28134

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D 367	Continued From page 23 administered to Resident #2 for a FSBS of 395mg/dl. -On 07/26/18 at 4:30pm there was no documentation the Novolog insulin was administered to Resident #2 for a FSBS of 259mg/dl. -On 07/27/18 at 4:30pm there was no documentation the Novolog insulin was administered to Resident #2 for a FSBS of 260mg/dl. -On 07/28/18 at 4:30pm there was no documentation the Novolog insulin was administered to Resident #2 for a FSBS of 263mg/dl. Review of Resident #2's MAR for August 2018 revealed: -There was an entry for a FSBS to be checked at 7:30am, 11:30am and 4:30 pm. -There was an entry for SSI with parameters as follows: for a FSBS of 200-225mg/dl, administer 5 units of insulin; for a FSBS of 226-250mg/dl, administer 8 units of insulin; for a FSBS of 251-300mg/dl, administer 11 units of insulin; for a FSBS of 301-350mg/dl, administer 14 units of insulin; for a FSBS above 351mg/dl, administer 17 units of insulin. -On 08/05/18 at 11:30pm there was no documentation the Novolog insulin was administered to Resident #2 for a FSBS of 386mg/dl. -On 08/12/18 at 4:30pm there was no documentation the Novolog insulin was administered to Resident #2 for a FSBS of 312mg/dl. -On 08/27/18 at 11:30am there was no documentation the Novolog insulin was administered to Resident #2 for a FSBS of 340mg/dl. -On 08/28/18 at 7:30am there was no	D 367		

10/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 24 documentation the Novolog insulin was administered to Resident #2 for a FSBS of 369mg/dl. -On 08/29/18 at 7:30am there was no documentation the Novolog insulin was administered to Resident #2 for a FSBS of 369mg/dl. -On 08/30/18 at 7:30am there was no documentation the Novolog insulin was administered to Resident #2 for a FSBS of 338mg/dl. -On 08/31/18 at 11:30am there was no documentation the Novolog insulin was administered to Resident #2 for a FSBS of 323mg/dl. Review of Resident #2's MAR for July and August 2018 revealed there was no documentation insulin was administered per sliding scale parameters on 15 occassions. Interview with the first shift Licensed Practical Nurse (LPN) on 09/05/18 at 3:10pm revealed: -She administered the insulin, per sliding scale orders, to Resident #2 on the day shift. -She would take the Insulin Binder from the clinic to the medication cart and document when she administered the insulin on the MAR. -She referred to the sliding scale parameters on the MAR after checking Resident #2's FSBS. -She did not know why she there were "holes" on days Resident #2's FSBS reading required administration of insulin, per sliding scale orders. -She knew she had administered the dosage as required and did not know why she did not document correctly. Telephone interview with the second shift LPN on 09/06/18 at 11:15am revealed: -She administered the insulin per sliding scale	D 367		

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D 367	Continued From page 25 orders to Resident #2 on the second shift. -The MAR for insulin documentation was kept in a binder in the clinic office. -She removed the MAR document from the binder and brought it to her medication cart to document. -She knew the sliding scale parameters were written on the MAR. -She always checked the sliding scale parameters before administering insulin. -She did not know why she did not enter the dosage of insulin she administered to Resident #2 when the blood sugar was above 200. -She was confident she administered the correct insulin on the days there was no documentation. -Interview with the Special Care Unit Coordinator (SCUC) on 09/06/18 at 3:20pm revealed: -The LPNs were responsible for checking the FSBS and administering insulin to the residents. -Resident #2 was the only resident who received SSI. -The Insulin Binder was kept in the Clinic Office for the LPNs to access and document when administering insulin and recording FSBS. -She thought the nurses removed the insulin binder, or the MARS in the binder, from the Clinic Office to the medication cart when administering insulin to the residents -The LPNs and medication aides were to review the MARS for any holes in the documentation before the end of their shift. -The third shift LPN was responsible for checking the documentation in the MARs, since she had more available time during the night shift. -The third shift nurse checked for any "holes" on the MAR, missing documentation a medication was administered. -Staff who were identified as having "holes" in their documentation would return to the facility the	D 367		

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D 367	Continued From page 26 next day to complete. -She did not know there were 15 occasions the LPNs did not document the dosage of insulin they administered. Interview with the Resident Service Director (RSD) on 09/06/18 at 3:40pm revealed: -The SCUC was responsible for the clinical oversite of the Special Care Unit (SCU). -She did not know the LPNs had not documented the administration of insulin for Resident #2 on 15 occasions in July and August. -She did not know the third shift nurse was not reviewing the MAR for holes. Attempted telephone interview with Resident #2's primary care physician on 09/06/18 at 1:05pm was unsuccessful. Telephone interview with the Executive Director (ED) on 09/07/18 at 9:01am revealed: -The SCUC was the clinical supervisor of the SCU. -The SCUC was an LPN and hired LPNs to administer medications and perform additional clinical duties. -The LPNs checked the FSBS and administered the insulin to the diabetic residents as ordered by the prescribing physician. -He did not know there were 15 occasions in the past 2 months Resident #2's insulin had not been documented as administered per physician's order. -He expected the LPNs to provide accurate documentation of the medications they administered.	D 367		