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THE HAVEN IN HIGHLAND CREEK	5920 MCCHESNEY DRIVE CHARLOTTE, NC 28269

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey on January 8-10, 2019.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 4 of 7 sampled residents (Resident's #1, #2, #6 and #7), related to the administration of an incorrect dosage of insulin for a diabetic resident (Resident #1); the incorrect liter flow of oxygen for a resident with a low level of oxygen in their blood (Resident #2); not checking the pulse before the administration of a medication that decreased blood pressure, not	D 358		

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administering a probiotic medication for digestive health and a scheduled laxative (Resident #6); and not administering a scheduled medication for bowel regularity (Resident #7).

The findings are:

The medication error rate was 11% as evidenced by 4 errors out of 35 opportunities observed during the 8:00am medication pass on 01/09/19.

1. Review of Resident #'6's current FL2 dated 08/01/18 revealed diagnoses included dementia with behavioral disturbances, asthma, gastroesophageal reflux (GERD), hypertension, hyperlipidemia and stomach ulcers.

a. Review of Resident #6's current FL2 dated 08/01/18 revealed an order for Verapamil HCL 240mg, hold for a pulse of less than 60.

Observation of the medication pass on 01/09/19 in Hall B at 8:10am revealed:
-The first shift medication aide (MA) dispensed 6 medications from their bubble cards into a medicine cup for Resident #6.
-Verapamil HCL was included as one of the tablets in the medicine cup.
-The MA attempted to hand the medication cup to Resident #6 without checking her pulse rate.

Observation of Resident #6's medications on hand for administration on 01/09/19 at 8:00am revealed a bubble card of 30 tablets of Verapamil HCL 240mg dispensed from the facility's contracted pharmacy.

Review of Resident #6's January 2019 MAR revealed there was an entry for Verapamil HCL 240 mg 1 caplet every day, hold for pulse less

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D 358	Continued From page 2 than 60, to be administered at 9:00am. Interview with the first shift MA on Hall B on 01/09/19 at 8:15am revealed: -She knew she should have taken Resident #6's pulse before administering the Verapamil HCL medication. -She did not usually work first shift as a MA. -The first shift medication pass was "very heavy" and she forgot to take Resident 6's pulse. -She was not sure why she should take the pulse before administration of the blood pressure medication. -She knew the pulse should be above 60 to administer the Verapamil medication. Interview with another first shift MA on 01/09/19 at 11:36am revealed: -She knew there were parameters on some medications. -She knew there were pulse parameters on Resident #6's blood pressure medication. -She always took Resident #6's pulse before administering Verapamil HCL. -If the pulse was less than 60 she would hold the medication and document the reason on the back of the MARs. -She knew the resident could become dizzy and unsteady if she administered the Verapamil and the resident's pulse was below 60. Interview with a third MA on first shift on 01/10/19 at 10:50am revealed: -She knew there were parameters on some medications. -She knew Resident #6 had parameters on her blood pressure medication. -She knew the pulse was to be taken before the administration of Verapamil HCL during the morning medication pass.	D 358		

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D 358	Continued From page 3 -"We just do not have time some days to do that" (take the pulse before the medication is administered). -The morning medication pass was "very heavy". -She did not know the possible outcome if Resident #6 had a pulse of less than 60 and was administered the Verapamil HCL. Interview with the Wellness Coordinator (WC) on 01/09/19 at 3:00 pm revealed: -The MAs were expected to follow the orders for the administration of medications on the MARs. -The parameters for a medication were an important part of an order. -The MAs were trained to take a pulse for some medications. -She did not know why a MA did not take the pulse for Resident #6's blood pressure medication. -She was very surprised a MA felt she did not have the time to take Resident #6's pulse before administering her blood pressure medication. Interview with the Resident Care Director (RCD) on 01/10/19 at 3:05pm revealed: -The MAs had been trained to read a medication order completely on the MARs and the medication bubble card. -Parameters in the administration of a medication were very important. -The MA administering medications this morning does not usually work first shift. -"I think she was overwhelmed" during the medication pass. -She does not know why the MAs are forgetting to check the parameters or think they are optional. -It was her responsibility to supervise and train the MAs. Interview with the Administrator on 01/10/19 at	D 358		

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D 358	Continued From page 4 3:15pm revealed: -The RCD needed more support in the "clinical aspect of her position". -She had requested a registered nurse (RN) to assist the RCD in the memory care neighborhoods. -They had been without an RN for 2 months. -She expected physician orders to be implemented by the staff as they were written. -It was the responsibility of the RCD and WC to provide supervision and training to the MAs. Based on observations, interviews and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with the primary care physician (PCP) on 01/10/19 at 10:20am was unsuccessful b. Review of Resident #6's current FL2 dated 08/01/18 revealed an order for Culturelle Pro-Well, take 1 caplet daily for digestive health. Observation of the medication pass on 01/09/19 in Hall B at 8:10am revealed the Culterelle ProWell probiotic medication for Resident #6 was not available for administration on the medication cart. Review of Resident #6's January 2019 MAR revealed there was an entry for Culturelle Pro-Well caplet to be administered daily at 9:00am Interview with the first shift MA on Hall B on 01/09/19 at 8:15am revealed: -She did not know where the Culturelle probiotic was. -She knew some medications were kept in the	D 358		

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clinic office as overstock.
-She would check the clinic, after her medication pass, for the probiotic.
-If the medication was not there she would report to her Supervisor.

Observation of the clinic office on 01/09/18 at 9:55am revealed there were no bubble cards for Culturelle ProWell with the back up medication.

Interview with the RCD on 01/10/19 at 3:05pm revealed:
-The MAs should request refill medications from the pharmacy when there was less than a 5 day supply remaining.
-The MAs could fax the pharmacy or call to request a refill medication.
-The MAs should inform the WC or RCD if the medications had not been delivered from the pharmacy within the following 24 hours.
-The pharmacy delivered medications in the evening of the day requested, if it was ordered before 4:00pm.
-If a prescription was necessary, she contacted the physician's office to request the refill prescription.
-She does not know why Culturelle probiotic was not available to administer to Resident #6.
-The MAs were not following the re-order process consistently.

Interview with the WC on 01/09/19 at 3:00 pm revealed:
-The MAs were expected to notify her or the RCD if medications were not on the medication cart.
-The MAs should be calling the pharmacy and requesting refill medications before the medication has run out.
-Refill requests for medications should be faxed to the pharmacy and followed up with a phone

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call for confirmation the request was received.
-Refill requests should be initiated when the medication had 3 or 4 doses remaining.
-She did not know the Culterelle probiotic was not on the medication cart for Resident #6.

Interview with the Administrator on 01/10/19 at 3:15pm revealed:
-There is a policy for medication refills, and the MAs should be following the policy.
-The RCD and WC should be reviewing the refill medication policy periodically with the MAs.

Based on observations, interviews and record reviews it was determined Resident #6 was not interviewable.

Attempted telephone interview with the PCP on 01/10/19 at 10:20am was unsuccessful

c. Review of Resident #6's current FL2 dated 08/01/18 revealed an order for Miralax powder 17 grams, add to 8 ounces of water, to be administered daily.

Observation of the medication pass on 01/09/19 in Hall B at 8:16am revealed:
-The MA was not able to locate the Miralax powder on the medication cart.
-Miralax powder, 17 grams to be mixed in 8 ounces water, was not administered to Resident #6.

Review of Resident #6's January 2019 MAR revealed there was an entry for Miralax powder, mix 17 grams in 8 ounces of water, to be administered daily at 9:00am

Interview with the first shift MA on Hall B on 01/09/19 at 8:30am revealed:

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-She did not know where the Miralax powder was.
-She knew some medications were kept in the clinic office as overstock.
-She would check the clinic, after her medication pass, for the Miralax.
-If the medication was not there she would report to her Supervisor.

Interview with the RCD on 01/10/19 at 3:05pm revealed:
-The MAs should order medications from the pharmacy when they have less than 5 days supply.
-The MAs could fax the pharmacy or call to request a refill medication.
-The MAs should inform the WC or RCD if the medications had not been delivered from the pharmacy within the following 24 hours.
-The pharmacy delivered medications in the evening of the day requested, if it was ordered before 4:00pm.
-If a prescription was necessary, she contacted the physician's office to request the refill prescription.
-She did not know why the Miralax was not available to administer to Resident #6.
-The MAs were not following the re-order process consistently.

Interview with the WC on 01/09/19 at 3:00 pm revealed:
-The MAs were expected to notify her or the RCD if medications were not on the medication cart.
-The MAs should be contacting the pharmacy for refill medication requests before they run out.
-The process for ordering medications was to fax or call the pharmacy when the medication has 3 or 4 doses remaining
-She did not know the Miralax powder was not on the medication cart for Resident #6.

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D 358	Continued From page 8 Attempted telephone interview with the responsible family member 01/10/19 at 2:50pm was unsuccessful Based on observations, interviews and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with the primary care physician (PCP) on 01/10/19 at 10:20am was unsuccessful Interview with the Administrator on 01/10/19 at 3:15pm revealed: -She did not know there were medications ordered for the residents and not on the medication cart. -There is a policy for medication refills, and the MAs should be following the policy. -The process for ordering medications was to fax or call the pharmacy when the medication has 3 or 4 doses remaining -She did not know the Miralax powder was not on the medication cart for Resident #6. 2. Review of Resident #7's current FL2 dated 12/14/18 revealed diagnoses included Alzheimer dementia, hypertension and coronary artery bypass graft (CABG). -Review of Resident #7's current FL2 dated 12/14/18 revealed an order for medications included Senna-S 8.6-50mg, 2 tablets every day, used as a bowel stimulant. Observation of the medication pass on 01/09/19 for Hall B at 9:05am revealed: -The first shift MA dispensed 4 tablets from their bubble cards into a medication cup.	D 358		

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D 358	Continued From page 9 - The MA could not locate the Senna-S bubble card on the medication cart. -The Senna-S tablets were not administered to Resident #7. Observation of Resident #7's medications available for administration on 01/09/19 at 9:10am revealed Senna -S was not on the medication cart for administration. Review of Resident #7's January 2019 MARs revealed there was an entry for Senna-S 8.6-50mg take 2 tabs, to be administered daily at 9:00am. Interview with the MA on 01/09/19 at 9:18am revealed: -She did not usually work this medication cart on first shift. -She did not know why Senna-S was not on the medication cart. -She could not find the Senna-S in the medication room. -She would call the pharmacy this morning to order the medication. -She would notify her supervisor the medication was not in the building. Interview with a second MA on 01/10/19 at 10:10am revealed: -She did not know why there were medications not found on the cart yesterday. -The MAs did not always follow the process for ordering refill medications. -She tried to order refill medications when she completed a cart audit. -She tried to do a cart audit weekly. -The last cart audit she completed was last week. Interview with the WC on 01/09/19 at 3:00pm	D 358		

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D 358	Continued From page 10 revealed: -The MAs were expected to notify her or the RCD if medications were not on the medication cart. -The MAs should be calling the pharmacy and ordering medications before they run out. -The process for ordering medications was to fax or call the pharmacy when the medication has 3 or 4 doses remaining -She did not know Senna-S was not on the medication cart for Resident #7. Interview with the Resident Care Director (RCD) on 01/10/19 at 3:05pm revealed: -The MAs should order medications from the pharmacy when they have less than 5 days supply. -The MAs could fax the pharmacy or call to request a refill medication. -The MAs should inform the WC or RCD if the medications had not been delivered from the pharmacy within the following 24 hours. -The pharmacy delivered medications in the evening of the day requested if it was ordered before 4:00pm. -If a prescription was necessary, she contacted the physician's office to request the refill prescription. -She did not know why the Senna-S was not available to administer to Resident #7. -The MAs were not following the re-order process consistently. Interview with the Administrator on 01/10/19 at 3:15pm revealed: -She expected medications for orders on the MARs to be available for administration. -It was the responsibility of the RCD and WC to ensure resident's medications were available for administration.	D 358		

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D 358	Continued From page 11 Based on observations and interviews, it was determined Resident # 7 was not interviewable. 3. Review of Resident #'2's current FL2 dated 01/30/18 revealed: - Diagnoses included dementia, cerebral vascular accident (CVA), atrial fibrillation, anemia, cor pulmonale, acute hypoxemia and respiratory failure. -Treatment orders included oxygen (O2) 2 liters (2L) via nasal cannula (NC) at bedtime. Review of Resident #2's subsequent physician's order dated 05/03/18 revealed there was an order to increase the oxygen delivery from 2L to 3L NC continuously. Observation of Resident #2 in her bedroom on 01/08/19 at 10:35am revealed: -Resident #2 was sitting in her wheelchair watching television. -The oxygen concentrator in the corner of the room was on, and her nasal cannula was in place. -The oxygen was set to 2.5L on the compressor cylinder. Interview with the first shift MA on 01/08/19 at 10:55am revealed: -The MAs were responsible for checking the oxygen concentrator for the correct liter flow, positioning of the nasal cannula, and the care of the tubing. -If the MAs were busy, the personal care aides (PCAs) checked the oxygen concentrator for the correct liter flow and positioning of the nasal cannula, but it was the responsibility of the MAs to document. -She stated Resident #2 was on continuous oxygen at 2 liters.	D 358		

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D 358	Continued From page 12 -The MA could not find an entry for the oxygen order on the January 2019 medication administration record (MAR). Interview with the second shift MA on 01/08/19 at 3:40pm revealed: -Resident #2 was on continuous oxygen at 2 liters, she thought. -It was the MAs responsibility to check the concentrator and the tubing on the nasal cannula. -She knew the correct liter flow because it was on the MARs. -The MA was unable to locate the entry on the January 2019 MARs. Review of Resident #2's September 2018 through December 2018 MARs revealed there were no entries for oxygen on the September, October, November or December 2018 MARs. Review of Resident #2's January 2019 MARs revealed there were no entries for oxygen on the January 2019 MARs. Telephone interview with the representative from the facility's contracted pharmacy on 01/09/19 at 11:30am revealed: -The pharmacy entered all orders for the facility onto the MARs. -The pharmacy staff was responsible for printing the MARs for the facility. -Resident #2's medication profile did not include any orders for oxygen administration. Interview with a second MA on first shift on 01/09/19 at 8:15am revealed: -The MAs were responsible for checking the oxygen concentrator for the correct liter flow, positioning of the nasal cannula, and the care of the tubing.	D 358		

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-If the MAs were busy, the personal care aides (PCAs) checked the oxygen concentrator for the correct liter flow and positioning of the nasal cannula.
-Resident #2 was on continuous oxygen at 2 liters.
-The MA could not find an entry for the oxygen order on the January 2019 MAR.
-She received reports daily from previous shifts and the Wellness Coordinator (WC).
-She did not remember being informed the oxygen order for Resident #2 had changed to 3L.

Interview with RCD on 1/09/19 at 3:00pm revealed:
-Physician orders received at the facility by the RCD, the WC or the MAs were faxed to the pharmacy..
-If an order was received after the MARs were printed by the pharmacy for the current month, she transcribed the handwritten order onto the MAR.
-If she was not at the facility, the WC or MA transcribed the handwritten order onto the MARs.
-The following month, the order would be entered by the pharmacy, typed on the MARs.
-She knew the oxygen order for Resident #2 had changed several months ago from 2L to 3L.
-She thought she had transcribed the new order onto the MARs.
-She did not know if the oxygen order, dated 05/03/18, had been faxed to the pharmacy.
-She did not know why the MAs thought Resident #2's oxygen was currently ordered at 2L.

Interview with a third MA on first shift on 01/10/19 at 10:15am revealed:
-She thought the oxygen order for Resident #2 was on the MAR.
-She knew Resident #2 was on oxygen because

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the MAs communicated treatment orders from shift to shift.
-She had been off for a few days, but she thought Resident #2 was currently on 3L of oxygen continuously.
-She did not know why it was not on the January 2019 MARs.
-She thought it had been on the MARs in the previous months.

Interview with the WC on 01/10/19 at 2:30pm revealed:
-Resident #2's oxygen order was for 3 liters nasal cannula continuous flow.
-The MAs check the concentrator to verify the nasal cannula is clean and applied correctly and the liter flow was set to the correct level.
-The MAs document on the MARs this task has been completed.
-She thought there was an entry for the oxygen order on the MARs.
-She was unable to locate the oxygen order on the MARs.
-She did not know why the MAs were confused as to the current oxygen order for Resident #2.

Interview with the second shift MA on 01/10/19 at 3:15pm revealed :
-Resident #2 was on continuous oxygen at 2 liters.
-It was the MAs responsibility to check the concentrator and the tubing on the nasal cannula.
-She knew the correct liter flow because it was on the MARs.
-The MA was unable to locate the entry on the January 2019 MARs.
-"I have always observed the oxygen set at 2 liters (for Resident #2).

Observation of the concentrator on 01/10/19 at

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D 358	Continued From page 15 3:30pm revealed a 3.5 liter flow. Interview with the nurse practitioner (NP) on 01/10/19 at 3:45pm revealed: -Resident #2's order for oxygen administration was for 3L continuous. -He did not know the entry for oxygen 3L continuous was not on the physician order he signed on 11/06/18. -Based on Resident #2's diagnoses, it was important the staff implement the current oxygen orders. Interview with the Administrator on 01/10/19 at 3:15pm revealed: -The RCD needed more support in the "clinical aspect of her position". -She had requested a registered nurse (RN) to assist the RCD in the memory care neighborhoods. -They had been without an RN for 2 months. -She expected physician orders to be implemented by the staff as they were written. -It was the responsibility of the RCD and WC to review and implement the physician's orders. 4. Review of Resident #1's current FL2 dated 09/04/18 revealed: -Diagnoses included encephalopathy, dementia with behaviors. -There was a subsequent physician order to administer Humalog KwikPen solution (used to treat high blood glucose) inject per sliding scale. Review of physician orders dated 09/14/18 revealed: -Resident #1 had a diagnosis of diabetes. -A medication order for Humalog KwikPen	D 358		

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D 358	Continued From page 16 solution (used to treat high blood glucose) Sliding Scale Insulin (SSI) four times daily; fingerstick blood sugar (FSBS) 0-200= 0 units, 201-250 = 2 unit, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-1000 = 10 units, repeat FSBS in 30 minutes and notify physician. Review of Resident #1's November 2018 Medication Administration Record (MAR) revealed: -There was an entry for Humalog KwikPen Solution SSI three times daily before meals and at bedtime, for FSBS 0-200= 0 units, 201-250 = 2 unit, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-1000 = 10 units, repeat FSBS in 30 minutes and notify physician. -The scheduled administrations times were 7:30am, 11:30am, 4:30pm, and 8:00pm. -On 11/01/18 at 11:30am, there was no FSBS recorded, no units documented as administered, and no reason documented indicating if the dosage was missed or refused. -On 11/14/18 at 8:00pm, there was a FSBS of 225 recorded, and 4 units of insulin was documented as administered. -On 11/16/18 at 8:00pm, there was a FSBS of 250 recorded, and 4 units of insulin was documented as administered. -On 11/23/18 at 11:30am, there was no FSBS recorded, no units documented as administered. -On 11/23/18 at 11:30am, it could not be determined if insulin was required, there was no reason documented indicating if the dosage was missed or refused. -On 11/25/18 at 11:30am, there was no FSBS recorded, no units documented as administered. -On 11/25/18 at 11:30am, it could not be determined if insulin was required, there was no reason documented indication if the dosage was missed or refused.	D 358		

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D 358	Continued From page 17 -On 11/26/18 at 11:30am, there was a FSBS of 274 recorded, and 2 units of insulin was documented as administered. Review of Resident #1's December 2018 MAR revealed: -There was an entry for Humalog KwikPen Solution SSI three times daily before meals and at bedtime, for FSBS 0-200= 0 units, 201-250 = 2 unit, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-1000 = 10 units, repeat FSBS in 30 minutes and notify physician. -The scheduled administrations times were 7:30am, 11:30am, 4:30pm, and 8:00pm. -On 12/10/18 at 4:30pm, there was no FSBS recorded, no units of insulin documented as administered. -On 12/10/18 at 4:30pm, it could not be determined if insulin was required, there was no reason documented indicating if the dosage was missed or refused. -On 12/10/18 at 8:00pm, there was no FSBS recorded, no units of insulin documented as administered. -On 12/10/18 at 8:00pm, it could not be determined if insulin was required, there was no reason documented indicating if the dosage was missed or refused. -On 12/14/18 at 7:30am, there was a FSBS of 247 recorded, and 4 units of insulin was documented as administered. -On 12/14/18 at 7:30am, there was no documentation that a repeat FSBS was completed. -On 12/13/18 at 8:00pm, there was a FSBS of 207 recorded, and 6 units of insulin was documented as administered. -On 12/14/18 at 7:30am, there was a FSBS of 247 recorded, and 4 units of insulin was documented as administered.	D 358		

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D 358	Continued From page 18 -On 12/14/18 at 8:00pm, there was a FSBS of 425 recorded, and 6 units of insulin was documented as administered. -On 12/26/18 at 8:00pm, there was a FSBS of 367 recorded, and no units of insulin was documented as administered. Review of Resident #1's January 2019 MAR revealed: -There was an entry for Humalog KwikPen Solution SSI three times daily before meals and at bedtime, for FSBS 0-200= 0 units, 201-250 = 2 unit, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-1000 = 10 units, repeat FSBS in 30 minutes and notify physician, with scheduled administrations times of 7:30am, 11:30am, 4:30pm, and 8:00pm. -On 01/01/19 at 7:30am, there was a FSBS of 250 recorded and no units of insulin was documented as administered. -On 01/03/19 at 4:30pm, there was no FSBS recorded, no units of insulin documented as administered. -On 01/03/19 at 4:30pm, it could not be determined if insulin was required, there was no reason documented indicating if the dosage was missed or refused. -On 01/04/19 at 11:30am, there was no FSBS recorded, no units of insulin documented as administered. -On 01/04/19 at 11:30am, it could not be determined if insulin was required, there was no reason documented indicating if the dosage was missed or refused. Interview on with the facility's contracted pharmacy representative on 01/09/19 at 10:24am revealed: -The pharmacy had received an order for Humalog KwikPen Solution SSI three times daily	D 358		

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before meals and at bedtime, for FSBS 0-200= 0 units, 201-250 = 2 unit, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-1000 = 10 units, repeat FSBS in 30 minutes and notify physician, with scheduled administrations times of 7:30am, 11:30am, 4:30pm, and 8:00pm.
-The order was dated 09/04/18.
-The pharmacy had no other Humalog Kwikpen Solution SSI orders.

Interview with a second shift medication aide (MA) on 01/09/19 at 3:10pm revealed:
-She administered insulin to Resident #1 according to the sliding scale.
-She always checked the resident's FSBS before she administered the insulin.
-She always referred to the sliding scale as listed on the MAR when administering insulin.
-She "forgot" to document on the MAR the amount of units she administered on 12/26/18 at 8:00pm.
-She did not know why Resident #1 was administered the wrong amount of insulin.
-The MAR was checked by MAs when changing shifts, "we didn't catch it".
-She did not know why she documented the wrong amount of insulin administered on 12/13/18 and 12/14/18 at 8pm; however thought that she documented in error and administered the correct amount.
-She had not noticed that she documented that she administered the incorrect amount of units on the MAR.

Interview with another second shift medication aide (MA) on 01/10/19 at 2:53pm revealed:
-She administered insulin according to the sliding scale for Resident #1.
-She checked the resident's FSBS and administered insulin according to the sliding

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scale.
-She did not know Resident #1 was administered the wrong amount of insulin as recorded on the MAR.
-MAs are supposed to check each other's MARs when changing shift, "but it does not always occur if MAs are too busy".
-She did not know she did not document the amount of units administered on 01/01/19 at 7:30am when Resident #1's FSBS was 250," I think I forgot, but I administered 2 units".

Interview with the Wellness Coordinator (WC) on 01/09/19 at 3:00 pm revealed:
-MAs were to check Resident #1's FSBS, record on the MAR and administer insulin according to the sliding scale.
-She did not realize that insulin was administered incorrectly or documented in error.
-MAs were expected to notify her of the Resident Care Director (RCD) if there was a medication error.
-She was supposed to check the MARs, weekly but she had been working as a MA recently.
-She had not been able to check the MARs as frequently, and checked "once per week".
-She checked as many MARs as she could weekly for accuracy of medication orders.
-She did not know of a process to check the MARs of insulin administration.

Interview with the RCD on 01/10/19 at 3:05pm revealed:
-MAs were supposed to check Resident #1's FSBS and administer insulin according to the sliding scale.
-The MAs were to record the FSBS and amount of insulin administered on the MAR and record on the back a reason if it was not administered.
-The MAs were supposed to administer only the

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D 358	Continued From page 21 amount of insulin as ordered per the sliding scale. -She did not know why the sliding scale had not been followed and why documentation was missing on the MAR. -She was responsible for checking the MAR for accuracy and had not completed the check "in a while" due to "staffing challenges". Telephone interview with the medical assistant at the primary care physician's (PCP) office on 01/09/19 at 12:15pm revealed: -The physician expected all orders to be followed as written. -She expected the facility to notify the Endocrinologist regarding any issues with insulin. -She had not been contacted by the facility regarding insulin administration. Interview with the Administrator on 01/10/19 at 3:15pm revealed: -She expected MAs to follow the physician's orders. -She did not know Resident #1 received the incorrect amount of insulin. -She expected the WC, RCD, and the supervisor-in-charge (SIC) to be reviewing the MAR for accuracy and holes weekly. -She expected the physician to be contacted if there is a medication error. Attempted telephone interview with the Endocrinologist on 01/09/19 at 12:19pm and 01/10/19 at 10:27am was unsuccessful. Based on observation, interview, and record review Resident #1 was not interviewable.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	Continued From page 22 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 Medication Administration Records (MARs) were accurate for 3 of 5 sampled residents (Resident #2, #6 and #1). The findings are: 1. Review of Resident #'2's current FL2 dated	D 367		

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D 367	Continued From page 23 01/30/18 revealed: - Diagnoses included dementia, cerebral vascular accident (CVA), atrial fibrillation, anemia, cor pulmonale, acute hypoxemia and respiratory failure. -Medications included oxygen (O2) 2 liters (2L) via nasal cannula (NC) at bedtime. Review of Resident #2's physician's order dated 05/03/18 revealed there was an order to increase the oxygen delivery from 2L to 3L NC continuously. Review of Resident #2's May 2018 through August 2018 MARs revealed handwritten entries for oxygen 3L continuous. Review of September 2018 through December 2018 MARS revealed there were no entries for oxygen 3L NC continuous on the September, October, November or December 2018 MARs. Review of Resident #2's January 2019 MARs revealed there were no entries for oxygen 3L NC continuous on the January 2019 MARs. Interview with the first shift medication aide (MA) on 01/08/19 at 10:55am revealed: -Resident #2 was on continuous oxygen at 2 liters. -The MA could not find an entry for the oxygen order on the January 2019 MARs, or demonstrate where the MAs documented the liter flow and positioning of the nasal cannula for Resident #2. Telephone interview with the representative from the facility's contracted pharmacy on 01/09/19 at 11:30am revealed: -The pharmacy entered all the orders they received from the facility onto the MARs.	D 367		

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D 367	Continued From page 24 -The facility was responsible for verifying all the orders on the MARs. -The pharmacy did not audit or review the MARs. -The pharmacy staff was responsible for printing the MARs and delivering them to the facility each month. -The facility was responsible for checking the MARs for accuracy and sending corrections to the pharmacy. Interview with a second shift MA on 01/08/19 at 3:40pm revealed: -Resident #2 was on continuous oxygen at 2 liters, she thought. -It was the MAs responsibility to check the concentrator and the tubing on the nasal cannula. -She knew the correct liter flow because it was on the MARs. -The MA was unable to locate the entry on the January 2019 MARs. Interview with another first shift MA on 01/09/19 at 8:15am revealed: -The MAs were responsible for checking the oxygen concentrator for the correct liter flow, positioning of the nasal cannula, and the care of the tubing. -If the MAs were busy, the personal care aides (PCAs) checked the oxygen concentrator for the correct liter flow and positioning of the nasal cannula. -She stated Resident #2 was on continuous oxygen at 2 liters. -The MA could not find an entry for the oxygen order on the January 2019 MAR. -She received reports daily from previous shifts and the Wellness Coordinator (WC). -She did not remember being informed the oxygen order for Resident #2 had changed to 3L.	D 367		

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D 367	Continued From page 25 Interview with a third MA on first shift on 01/10/19 at 10:15am revealed: -She thought the oxygen order for Resident #2 was on the MARs. -She knew Resident #2 was on oxygen because the MAs communicated treatment orders from shift to shift. -She had been off for a few days, but she thought Resident #2 was on 3L of oxygen continuously. -She did not know why it was not on the January 2019 MARs. -She thought it had been on the MARs in the previous months. Interview with Resident Care Director (RCD) on 1/10/19 at 3:05pm revealed: -The RCD, the WC or the MAs faxed physician orders for the residentsd to the pharmacy. -If an order was received after the MARs were printed for the current month, she transcribed the handwritten order onto the MARs. -If she was not at the facility, the WC or MA transcribed the handwritten order onto the MARs. -After the orders were faxed to the pharmacy, they were placed in a binder for the RCD to review. -For the upcoming month, the orders should be entered on the MARs by the pharmacy. -She and the WC reviewed the current MARs with the past month's MARs to ensure all new orders had been entered accurately. -She reviewed a random sample of the MARs most recently in December 2018 for accuracy. -Cart audits were performed monthly by the first shift MA and the Wellness Coordinator. -She knew the oxygen order for Resident #2 had changed several months ago from 2L to 3L. -She thought she had transcribed the new order onto the MARs each month. -She did not follow up with the pharmacy to	D 367		

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determine why the oxygen order was not entered on the MARs by the pharmacy.
-She did not know the pharmacy did not have Resident #2's oxygen order for 3L NC dated 05/03/18.
-She did not know why the MAs thought Resident #2's oxygen was ordered at 2L.

Interview with the Wellness Coordinator (WC) on 01/09/19 at 3:00pm revealed:
-Resident #2's oxygen order was for 3 liters nasal cannula continuous flow.
-The MAs checked the concentrator to verify the nasal cannula was clean and applied correctly and the liter flow was set to the correct level.
-The MAs documented on the MARs when this task had been completed.
-She thought there was an entry for Resident #2's oxygen order on the MARs.
-She was unable to locate the oxygen order on the MARs or identify where the MAs would document they had completed the task.
-It was her responsibility, along with the RCD, to review the current MARs and the previous month's MARs to ensure all orders had been entered correctly.
-"I guess we just missed it (the oxygen 3L NC order) in September."

Refer to interview with the Administrator on 01/10/19 at 3:15pm.

2. Review of Resident #'6's current FL2 dated 08/01/18 revealed:
- Diagnoses included dementia with behavioral disturbances, asthma, gastroesophageal reflux (GERD), hypertension, hyperlipidemia and stomach ulcers.
-Medications included Verapamil HCL 240mg for hypertension, hold for pulse less than 60.

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THE HAVEN IN HIGHLAND CREEK	5920 MCCHESNEY DRIVE CHARLOTTE, NC 28269

(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 367	Continued From page 27 Review of January 2019 MARs revealed; -There was an entry for Verapamil HCL 240mg, administer 1 capsule daily, hold for pulse less than 60. -On 01/01/19 there was no documentation of a pulse reading. The medication was documented as administered. -On 01/02/19 there was no documentation of a pulse reading. The medication was documented as administered. -On 01/05/19 there was no documentation of a pulse reading. The medication was documented as administered. Interview with a first shift MA on Hall B on 01/09/19 at 8:15am revealed: -She did not usually work first shift as a MA. -She knew she should have taken Resident #6's pulse before administering the Verapamil HCL medication. -She was not sure why she should take the pulse before administration of the blood pressure medication. -She knew the pulse should be above 60 to administer the medication. -"The medication pass in the morning is very heavy and I forgot." Interview with the RCD on 01/10/19 at 3:05pm revealed: -The MAs are supposed to check each others MARs at the end of the shift and make sure "there are no holes" (medications or treatments that have not been signed as completed by the MA). -The MAs have been instructed to read the complete order on the MAR. -Parameters for a medication were part of a complete order.	D 367		

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D 367	Continued From page 28 Refer to interview with the Administrator on 01/10/19 at 3:15pm. 3. Review of Resident #1's current FL2 dated 09/04/18 revealed diagnoses included encephalopathy, dementia with behaviors. a. Review of Resident #1's current FL2 dated 09/04/18 revealed a medication order to administer Humalog KwikPen solution (treat high blood glucose) inject per sliding scale. Review of physician orders dated 09/14/18 revealed: -Resident #1 had a diagnosis of diabetes. -A medication order for Humalog KwikPen solution (used to treat high blood glucose) Sliding Scale Insulin (SSI) four times daily; fingerstick blood sugar (FSBS) 0-200= 0 units, 201-250 = 2 unit, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-1000 = 10 units, repeat FSBS in 30 minutes and notify physician. Review of Resident #1's November 2018 Medication Administration Record (MAR) revealed: -There was an entry for Humalog KwikPen Solution SSI three times daily before meals and at bedtime, for FSBS 0-200= 0 units, 201-250 = 2 unit, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-1000 = 10 units, repeat FSBS in 30 minutes and notify physician. -The scheduled administrations times were 7:30am, 11:30am, 4:30pm, and 8:00pm. -On 11/01/18 at 11:30am, there was no FSBS recorded, no units documented as administered, and no reason documented indicating if the dosage was missed or refused.	D 367		

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D 367	Continued From page 29 -On 11/23/18 at 7:30am, FSBS results was illegible, and no units documented as administered, and no explanation documented on the back of the MAR. -On 11/23/18 at 11:30am, there was no FSBS recorded, no units documented as administered, and no reason documented indicating if the dosage was missed or refused. -On 11/25/18 at 11:30am, there was no FSBS recorded, no units documented as administered, and no reason documented indicating if the dosage was missed or refused. Review of Resident #1's December 2018 MAR revealed: -There was an entry for Humalog KwikPen Solution SSI three times daily before meals and at bedtime, for FSBS 0-200= 0 units, 201-250 = 2 unit, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-1000 = 10 units, repeat FSBS in 30 minutes and notify physician, with scheduled administrations times of 7:30am, 11:30am, 4:30pm, and 8:00pm. -On 12/10/18 at 8:00pm, there was no FSBS recorded, no units of insulin documented as administered, and no reason documented indicating if the dosage was missed or refused. -On 12/26/18 at 8:00pm, there was a FSBS of 367 recorded, and no units of insulin was documented as administered, and no reason documented for the omission. Review of Resident #1's January 2019 MAR revealed: -There was an entry for Humalog KwikPen Solution SSI three times daily before meals and at bedtime, for FSBS 0-200= 0 units, 201-250 = 2 unit, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-1000 = 10 units, repeat FSBS in 30 minutes and notify physician, with	D 367		

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scheduled administrations times of 7:30am, 11:30am, 4:30pm, and 8:00pm.
-On 01/01/19 at 7:30am, there was a FSBS of 250 recorded and no units of insulin was documented as administered, and no reason documented for the omission.
-On 01/03/19 at 4:30pm, there was no FSBS recorded, no units of insulin documented as administered, and no documentation of the reason it was not administered.
-On 01/04/19 at 11:30am, there was no FSBS recorded, no units of insulin documented as administered, and no documentation of the reason it was not administered.
-On 01/05/19 at 11:30am, FSBS results was illegible, and no units documented as administered, and no explanation documented on the back of the MAR

Interview with a second shift medication aide (MA) on 01/09/18 at 3:10pm revealed:
-She administered insulin to Resident #1 according to the sliding scale.
-She always checked the resident's FSBS before she administered the insulin.
-She "forgot" to document on the MAR the amount of units she administered on 12/26/18 at 8:00pm.
-The MAR was checked by MAs when changing shifts, "we didn't catch it".
-She did not know why she documented the wrong amount of insulin administered on 12/13/18 and 12/14/18 at 8pm; however thought that she documented in error and administered the correct amount.
-She had not noticed that she documented that she administered the incorrect amount of units on the MAR.
-She did not know why there was missing documentation on the MAR.

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D 367	Continued From page 31 -There was not supposed to be any blanks on the MAR, reasons for not administering was to be documented on the back of the MAR. Interview with another second shift medication aide (MA) on 01/10/19 at 2:53pm revealed: -She administered insulin according to the sliding scale for Resident #1. -She checked the resident's FSBS and administered insulin according to the sliding scale. -MAs are supposed to check each other's MARs when changing shift, "but it does not always occur if MAs are too busy". -She did not know why she did not document the amount of units administered on 01/01/18 at 11:30am," I think I forgot, but I administered 2 units". Interview with a first shift medication aide (MA) on 01/10/19 at 11:50am revealed: -She checked Resident #1's FSBS at 7:30am and 11:30am when she worked and always record results on the MAR. -She administered insulin according to the sliding scale as listed on the MAR. -The MAR should never be blank, if a medication is not administered, the reason should be recorded on the back of the MAR. -She did not know who was responsible for checking the MAR for accuracy. Interview with the Wellness Coordinator (WC) on 01/09/19 at 3:00 pm revealed: -MAs were to check Resident #1's FSBS, record on the MAR and administer insulin according to the sliding scale. -She did not realize that insulin units were missing or documented in error on Resident #1's MAR.	D 367		

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D 367	Continued From page 32 -MAs were expected to notify her or the Resident Care Director (RCD) if there was a medication error. -She was supposed to check the MARs but she had been serving as a MA recently due to limited staff. -She had not been able to check the MARs as frequently, she checked them "once per week". -She checked as many MARs as she could weekly for accuracy of medication orders. -She did not know of a process to check the MARs for accurate insulin administration. Interview with the RCD on 01/10/19 at 3:05pm revealed: -MAs were supposed to check Resident #1's FSBS and administer insulin according to the sliding scale. -The MAs were to record the FSBS and amount of insulin administered on the MAR and record on the back a reason if it was not administered. -She did not know why documentation for insulin administration was missing on the MAR for Resident #1. -She was responsible for checking the MAR for accuracy and had not completed the check "in a while" due to staffing challenges. Refer to interview with the Administrator on 01/10/19 at 3:15pm. b. Review of a medication order for Resident #1 dated 12/21/18 revealed an order for lorazepam (used to treat anxiety) 0.5mg one tablet daily as needed for traveling anxiety. Review of Resident #1's December 2018 and January 2019 MAR revealed there was no entry for lorazepam 0.5mg one tablet daily as needed for traveling anxiety.	D 367		

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D 367	Continued From page 33 Telephone interview with a representative from the contracted pharmacy on 01/09/18 at 10:24am revealed: -On 12/21/18 an order was received for Resident #1's lorazepam 0.5mg one tablet daily as needed. -The order for lorazepam 0.5mg was not included on the MAR in error, "it was missed". -The pharmacy had dispensed 15 tablets of lorazepam 0.5mg on 12/21/18; no additional fill history. -The facility had not notified them that the lorazepam 0.5mg was not on the MAR. -The facility was supposed to notify them if there were medications missing from the MAR. Interview with a first shift medication aide (MA) on 01/10/19 at 11:50am revealed: -New orders were received and processed by the Wellness Coordinator (WC) or the Resident Care Director (RCD). -She administered medications as they appeared on the MAR. -She did not know Resident #1 had an order for lorazepam 0.5mg because it was not on the MAR. -She would have administered lorazepam 0.5mg if she knew Resident #1 had an order because he had previously displayed anxiety in December 2018. Interview with the Wellness Coordinator (WC) on 01/09/19 at 3:00 pm revealed: -She and the RCD were responsible for receiving and transcribing new orders on the MAR. -At times, the supervisor-in-charge (SIC) were responsible if she or the RCD is not available. -A copy of the new order was supposed to be placed in the "copies of physician's orders" binder and reviewed by her or the RCD to make sure the	D 367		

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D 367	Continued From page 34 order was placed on the MAR. -There had been a problem with orders appearing on the MAR since changing to a new pharmacy provider. -She was supposed to check the MARs but she had been serving as a MA recently due to limited staff. -She had not been able to check the MARs as frequently, and had checked them "once per week". -She checked as many MARs as she could weekly for accuracy of medication orders. -She did not know why Resident #1's lorazepam 0.5mg was not printed on the MAR, "it was an oversight". Interview with the RCD on 01/10/19 at 3:05pm revealed: -New orders were to be reviewed by her, the WC or the SIC. -She, the WC, and SIC were responsible for transcribing the medication order on the MAR, faxing to the pharmacy and placing in the "copies of physician's orders" binder and she was to complete a final check. -MARs were also to be checked at the end of each month for accuracy and the pharmacy was to be notified of any missing medications. -She did not know why Resident #1's lorazepam 0.5mg was not entered onto the MAR. -She was responsible for checking the MAR for accuracy and had not completed the check "in a while" due to staffing challenges. Refer to interview with the Administrator on 01/10/19 at 3:15pm. _____ Interview with the Administrator on 01/10/19 at 3:15pm revealed the RCD and WC are	D 367		

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D 367	Continued From page 35 responsible for providing oversite with the MAs and their documentation on the MARs.	D 367		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to report an injury of unknown origin to the Health Care Personnel Registry (HCPR) as required for 1 of 5 sampled residents (Resident #2). The findings are: Review of Resident #2's current FL2, signed 01/30/18, revealed: -Diagnoses included dementia, cerebral vascular accident with right hemiparesis, over active bladder, anemia of chronic disease, generalized osteoarthritis, acute hypoxemia respiratory failure, mucus plugging, generalized weakness and deconditioning, and hypertension. -Resident #2 required a secured unit. Review of Resident #2's incident report dated 01/04/19 at 10:45am revealed: -Resident #2 was in her room when it was observed that she had an injury to the "right lower	D 438		

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extremity."
-"I was called to the resident's room by the nurses assistant because she was complaining of pain saw swelling and bruise call 911 and family, sent to hospital."
-Resident #2 returned from the hospital with an order to follow up with primary care physician, and to "monitor bruise until resolved, update physician on any changes."

Review of Resident #2's care notes revealed there was no documentation regarding any incidents or accidents.

Telephone interview with Resident #2's Physical Therapist (PT) on 01/10/19 at 10:45am revealed:
-She saw Resident #2 on 01/03/19.
-She went into Resident #2's room and the Wellness Coordinator (WC) was putting on Resident #2's TED hose. She observed Resident #2 to have "a lot of dark purple bruising between her knee and thigh to her hip on her right leg." There was not any swelling of her knee at that time.
-Resident #2 already had a shirt on, so she was not able to see the bruising on her elbow.
-Due to the color of the bruising and the fact that there was not any swelling appearing, she estimated that the injury had occurred very recently within the last 24 hours, or possibly overnight prior to her seeing it on 1/3/19 at approximately 7:30am.
-At the time she observed the injury she asked the WC "What happened to her leg?" and the WC said "she did not know."
-On 1/7/19 she asked if anyone had determined what had happened to Resident #2 to cause the bruising, but no one knew anything.
-Resident #2 would "never" be able to get herself up without assistance if she had fallen.

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D 438	Continued From page 37 -Resident #2 had weakness on the right side of her body related to a cerebrovascular accident (CVA) she had previously. Review of Resident #2's physical therapist's (PT) notes revealed: -She documented that on 01/03/19 Resident #2 complained of "hurting all over." She documented Resident #2's right lower extremity (knee and thigh) had purple bruises. -She documented that on 01/07/19 Resident #2 had "bruising along her right lower extremity and right elbow and right scapula (greenish-purple)." Interview with WC on 01/10/19 at 4:05pm revealed: -She had first observed bruising on Resident #2 on 1/3/19 when she was dressing her that morning, and "pointed it out to the PT", who was also in the room. -At that time, the bruising was just a "small area" about the size of a quarter or a little bigger, middle ways her right thigh. The bruising was not dark in color. -She had not reported the bruising to anyone and did not complete an incident report at the time the injury was observed because "it was so minor." -No one had reported any falls or accidents with Resident #2 to her when she arrived on 1/3/19. -The Resident Care Director (RCD) had contacted her the next morning to ask about the bruising on Resident #2 after it was observed that morning (1/4/19) when the personal care aide (PCA) was getting her dressed. Interview with the RCD on 1/10/19 at 3:20pm revealed: -She first became aware of the bruising on Resident #2 when she arrived to work on 01/04/19.	D 438		

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D 438	Continued From page 38 -The PCA who went in to get her dressed had observed the dark bruising and swelling to Resident #2's knee. -She went to Resident #2's room and observed Resident #2's right leg was "swollen and bruised from the knee up." -She agreed with the PCA that Resident #2 should be sent to the hospital for evaluation. -She immediately contacted the WC, who was off that day, to inquire if she had observed any injury to Resident #2 or if anyone had reported anything to her. -The WC told her that she and the PT had observed some bruising on Resident #2's right leg the prior morning, but at that time it was "not significant." -The WC told her she had forgotten to complete an incident report at the time the bruising was identified. -When residents were observed with injuries, staff were supposed to notify her immediately. No one had notified her of Resident #2's injury on 01/03/19. -She was "just getting organized" to begin an investigation into how the injury had occurred, when Resident #2 had returned from the hospital. -She had spoken with hospital staff prior to Resident #2 returning, and it was her understanding that the bruising and swelling was not related to an injury, so she did not proceed to investigate the cause of the bruising any further. -She did not report the bruising and swelling of Resident #2's leg to the HCPR because she did not feel it was an "injury of unknown origin." Review of the facility's incident/accident reporting process policy revealed: -"an incident/accident will be handled in a manner to promote the safety and health of individual(s) involved. Documentation will occur as soon as	D 438		

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D 438	Continued From page 39 the situation has been stabilized and secure and not more than 24 hours after the occurrence, with an internal investigation to follow if indicated ..." -An incident/accident is defined as being "any event that is not consistent with routine client care and services as defined by the company. Any event reportable to state agencies as defined by those agencies. Any event involving a client with unintended, undesirable or unexpected results or outcome." -Documentation of incidents/accidents included a list of examples that were considered "serious in nature and thus require the completion of a written incident/accident report" the list included falls and "client injury of unknown origin (bruising, lacerations, etc)." -"The Agency Administrator/Executive Director (or designee) is responsible for notifying the following individuals/agencies of all incidents/accidents: Appropriate agencies as required by state-specific regulations ..." -Examples of emergency situations that require intervention/treatment in an acute setting included "suspected fractures." -Proper notification of incidents/accidents included: "Employee will notify the Clinical Director/Nurse Supervisor, family/responsible party will be notified, clinical director/nurse supervisor will notify agency administrator, and executive director, employee will complete incident/accident report." -The "Documentation" portion of the policy notes "investigation summary of incidents-accidents of unknow origin" Interview with Administrator on 01/10/19 at 4:40pm revealed: -She was aware that Resident #2 had been sent out for evaluation on 01/04/19 for bruising on the elbow and leg.	D 438		

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D 438	Continued From page 40 -No staff were aware of Resident #2 having an incident prior to the bruising being identified on 01/03/19 and no incident report was completed prior to 01/04/19. -At the time Resident #2 was sent out, she had told the RCD that a 24 hour investigation needed be launched to determine how the resident became injured. -When Resident #2 returned later that day, the RCD had informed her that the hospital documentation reflected that the bruising was a result of Resident #2's coumadin therapy, so they did not pursue conducting an investigation, or reporting to the HCPR as they felt it was no longer "an injury of unknown origin." -It was the RCD's responsibility to launch an investigation anytime there was an injury of unknown origin and to report to the HCPR. -The LHPS nurse would assist the RCD with any investigations and reporting to the HCPR. -The facility did not report this incident to the HCPR.	D 438		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure all residents	D912		

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D912	Continued From page 41 received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to resident rights. The findings are: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 5 sampled residents (Resident #2) was free from neglect, related to staff not seeking immediate medical evaluation and treatment for right knee and right elbow pain with bruising. The injuries were identified by a licensed physical therapist, and the resident was not sent out for evaluation until 24 hours later. [Refer to Tag 914 G.S. 131D-21(4) Declaration of Residents' Rights (Type A2 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure 1 of 5 sampled residents (Resident #2) was free from neglect, related to staff not seeking immediate medical evaluation and treatment for right knee and right elbow pain with bruising. The injuries were identified by a licensed physical therapist, and the resident was not sent out for evaluation	D914		

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D914	Continued From page 42 until 24 hours later. The findings are: Review of Resident #2's current FL2 signed 01/30/18 revealed: -Diagnoses included dementia, cerebral vascular accident with right hemiparesis, over active bladder, anemia of chronic disease, generalized osteoarthritis, acute hypoxemia respiratory failure, mucus plugging, generalized weakness and deconditioning, and hypertension. -Resident #2 required a special care unit (SCU). Review of Resident #2's care notes revealed there was no documentation regarding any incidents or accidents. Review of Resident #2's current care plan dated 02/08/18 revealed: -Resident #2 was a "one person assist" with regards to dressing, bathing, toileting, ambulation and transfers. -She could "stand and pivot" with transfers and used a wheelchair, requiring staff assistance with ambulation. Review of Resident #2's Special Care Unit (SCU) profile, dated 10/10/18 revealed Resident #2 was "not able to transfer independently." Interview with a MA on 01/10/19 at 2:06 revealed: -She had worked 1st shift on 01/02/19 as a PCA and thought she had dressed Resident #2 that morning. -She did not recall anything out of the ordinary that day with Resident #2. -Resident #2 did not usually have any pain, and she did not recall her having any pain that day.	D914		

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D914	Continued From page 43 Review of Resident #2's physical therapist's (PT) notes revealed: -On 01/03/19 Resident #2 complained of "hurting all over." -Resident #2's right lower extremity (knee and thigh) had purple bruises. Telephone interview with Resident #2's PT on 01/10/19 at 10:45am revealed: -Resident #2 had been receiving "personal fitness" training from her for several years to aide her in maintaining her mobility as much as possible. -She worked with Resident #2 twice a week. -She had seen Resident #2 on 12/31/18 and had not observed any bruising or swelling. Resident #2 was not having any pain symptoms and did not usually have chronic pain. -She saw Resident #2 again on 01/03/19. When she arrived at the facility between 7 and 7:30am on that day Resident #2 was still in bed. She told staff that they could leave her in bed and she would get her up when she went in to work with her after she finished with another client. -She went into Resident #2's room and the Wellness Coordinator (WC) was putting on Resident #2's TED hose. She observed Resident #2 to have "a lot of dark purple bruising between her knee and thigh to her hip on her right leg." There was not any swelling of her knee at that time. -Resident #2 already had a shirt on, so she was not able to see the bruising on her elbow. -At the time she observed the injury she asked the WC "What happened to her leg?" and the WC said "she did not know." -After the WC left the room, she attempted to sit Resident #2 up and she said "I hurt all over." She asked the medication aide (MA) to administer something for pain.	D914		

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D914	Continued From page 44 -On 01/04/19 a staff member called her and asked if anything had happened while she was there on 01/03/19 working with her because she had observed significant bruising on her right side. She told her the WC was present at the time she had observed it the previous day. -She visited the facility on 01/07/19 and learned Resident #2 had been sent out the morning of 01/04/19 to have x-rays due to her pain level, bruising, and swelling. -Resident #2 would "never" be able to get herself up without assistance if she had fallen. -Resident #2 had weakness on the right side of her body related to a CVA she had previously. -Resident #2's right leg had a tendency to "slide out from under her" and for that reason, when she worked with her she always made sure she "blocked" her right foot in case it started to slide, to prevent her from falling. -Resident #2 had previously had bed and chair alarms in place, however, recently she was no longer trying to get up without assistance so they were no longer being used. -She did not know of any new fall measures that had been put in place since Resident #2's injury on 01/03/19. -Resident #2 had declined some in her mobility and ability to assist with transfers in the past few months and should have been a "2 person assist" by staff. -She had seen Resident #2 again this morning and the resident was still "very sore." She was not able to do a lot of the exercises they normally did because of her injuries and pain level. -Resident #2 was on coumadin, which could make bruising worse, however, the bruising would not manifest without some type of trauma. There was "no way" Resident #2's bruising was related to her coumadin without some type of accident to cause the bruising to appear. The	D914		

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severity and size of Resident #2's bruising would have to be caused by a significant trauma and not "just a bump."

Interview with the WC on 01/10/19 at 4:05pm revealed:
-She had first observed bruising on Resident #2 on 01/03/19, while she was dressing her.
-The PT was also in the room and she pointed it out to the PT.
-At that time, the bruising was just a "small area" about the size of a quarter or a little bigger, middle ways her right thigh. The bruising was not yet dark in color.
-She had not reported the bruising to anyone and did not complete an incident report at the time the injury was observed because "it was so minor."
-No one had reported any falls or accidents with Resident #2 to her when she arrived on 01/03/19.
-The Resident Care Director (RCD) had contacted her the next morning to ask about the bruising on Resident #2 after it was observed that morning (01/04/19) when the PCA was getting her dressed.

Review of Resident #2's incident report dated 01/04/19 at 10:45am revealed:
-Resident #2 was in her room when it was observed that she had an injury to the "right lower extremity."
-"I was called to the resident's room by the personal care assistant (PCA) because she was complaining of pain saw swelling and bruise call 911 and family, sent to hospital."
-No information was documented in the "injury type" section of the report.
-The resident was sent to the hospital for evaluation and her primary care physician was notified.
-Resident #2 returned from the hospital with an

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order to follow up with primary care physician, and to "monitor bruise until resolved, update physician on any changes."

Review of Resident #2's hospital discharge documentation, dated 01/04/19, revealed:
-Resident #2 was evaluated for "elbow pain" and "knee pain."
-Resident #2 was diagnosed with "contusion of the right knee", "elbow pain, unspecified laterally" and "coumadin toxicity, accidental or unintentional, initial encounter."
-Included in the discharge documentation was information on "acute pain," "soft tissue contusion," and "lower extremity contusion."

Review of Resident #2's emergency services transport report dated 01/04/19 revealed:
-Resident #2 was "complaining of pain to her right knee and elbow."
-Her lower extremities were noted to have "signs of injury" including swelling and bruising and pain to right knee.
-Her upper extremities were noted to have "signs of injury" including pain without swelling, with some bruising around the right elbow. She "refused to straighten out her elbow or allow medic to do so."
-"Staff were unsure what had caused the injuries."
-Resident #2 was "unable to sit, stand, or walk without assistance."

Review of Resident #2's hospital "history" report dated 01/04/19 revealed:
-She was seen for "right knee pain and right elbow pain."
-She "got up with staff assistance today and was found to have knee and elbow pain."
-There was "no known definite injury."

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D914	Continued From page 47 -There was no evidence of fractures on the x-rays of her knee and elbow. -Her right knee was noted to have "swelling and pain with flexion extension." -Her right elbow was "held in flexion. Pain with extension." -It was documented that the swelling appeared to be traumatic. Review of Resident #2's Assisted Living to Hospital Transfer Form dated 01/04/19 revealed: -The reason for transfer was documented as "pain to right side difficult to move." -The pain level was documented to be a "10/10" -The pain location was documented as "right side leg, knee, hip." Observation of Resident #2 on 01/10/19 at 1:29pm revealed: -Resident #2's right knee, lower thigh and calf were 80% covered by dark purple-bluish bruising that went all the way around the circumference of her thigh, knee, and calf. -Resident #2's lower thigh, right knee, and calf had significant swelling. -Resident #2 was wearing pants, so nothing above the lower thigh could be observed. -Resident #2 was wearing TED hose, but could not tolerate them being pulled up over her knee when staff attempted to do so, due to her pain level related to her injury, so the TED hose were rolled down below her knee. When staff attempted to pull the TED hose over her knee she grimaced. -Resident #2's right elbow was swollen and had approximately a 4 inch diameter area of bruising all around the elbow which was yellow-greenish in color. -Resident #2 was "guarding" her right arm. She did not want her arm moved at all as staff	D914		

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attempted to take off her sweater and put it back on after the assessment of her elbow was completed.
-She was unable to straighten her right arm upon request and would not attempt to do so.

Interview with a personal care aide (PCA) on 01/10/19 at 11:35am revealed:
-She had worked 1st shift in the unit Resident #2 resided in on 01/03/18 as a PCA, but was not assigned to assist Resident #2 with her needs that day.
-The physical therapist had come in that morning and said that she would get Resident #2 up when she went in to work with her.
-The WC was in Resident #2's room getting her up and dressed when the physical therapist went into her room.
-The WC and the PT observed some bruising on Resident #2's leg at that time.
-No incidents or accidents with Resident #2 had been reported the previous day or by the previous shift.
-The WC had reported to her that she "had some minor bruising but she was okay."
-She had "no idea how bad it was" until she learned that Resident #2 was sent out the next day.
-Resident #2 used to try to sit herself up but she has not been doing so recently.
-Resident #2 could no longer offer much support when staff were trying to stand her up.
-The resident's decreased ability to assist with transfers had changed in the "last month or two."

Interview with a MA on 01/10/19 at 2:06 revealed:
-She worked again on 01/04/19 as the MA in Resident #2's unit. She recalled the PCA that was assigned to Resident #2 that day notified her that the resident had bruising and swelling. She went

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to assess the resident in bed and observed bruising and swelling to her right leg and right elbow.
-At the time she had assessed Resident #2, the RCD was on her way to the community and came to assess the resident a short time later and the decision was made to send Resident #2 to the hospital for evaluation.
-She was not aware of Resident #2 having any incidents or accidents while living in the facility and none had been reported to her by the previous shift.

Interview with another PCA on 01/09/19 at 2:45pm revealed:
-She had worked in the unit in which Resident #2 resided and was assigned to assist Resident #2 with her needs on 01/04/19.
-On 01/04/19, she was unable to get Resident #2 up and dressed because the resident was in "extreme pain." She then assessed the resident and "immediately noticed that her knee was swollen and green." She also observed bruising on her thigh and elbow.
-She immediately reported her observation of Resident #2 to the MA, who came to assess her. She and the MA made the decision to wait for the RCD to arrive, to assess her before sending her out. The RCD arrived within 30 minutes, and agreed she needed to be sent to the hospital for evaluation.
-Resident #2 was not able to transfer and ambulate without assistance.
-Resident #2 did not have any chronic pain, so it was unusual for her have any pain as she did that morning.
-No one that had worked on 3rd shift had reported any injuries or accidents with Resident #2 to her when she arrived for her shift on 01/04/19.

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D914	Continued From page 50 Interview with the RCD on 01/10/19 at 3:20pm revealed: -She first became aware of the bruising on Resident #2 when she arrived to work on 01/04/19. -The PCA who went in to get her dressed had observed the dark bruising and swelling to Resident #2's knee. The PCA did not proceed to dress the resident after observing the injury and notified her that the resident needed to be assessed. -She went to Resident #2's room and observed Resident #2's right leg was "swollen and bruised from the knee up." -She agreed with the PCA that Resident #2 should be sent to the hospital for evaluation. -She immediately contacted the WC, who was off that day, to inquire if she had observed any injury to Resident #2 or if anyone had reported anything to her. The WC told her that she and the PT had observed some bruising on Resident #2's right leg the prior morning, but at that time it was not significant. The WC told her she had forgotten to complete an incident report at the time the bruising was identified. -The WC had told her she did mention it to Resident #2's responsible party (RP) when they had visited for lunch the day before. -When residents were observed with injuries, staff were supposed to notify her immediately. No one had notified her of Resident #2's injury on 01/03/19. -She did not think the injury was from an accident, and therefore, she did not proceed to investigate the cause of the bruising any further. -She did not report the bruising and swelling of Resident #2's leg to the HCPR because she did not feel it was an "injury of unknown origin." -Resident #2 was not able to transfer without	D914		

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assistance and would "never" be able to get up from a fall without assistance from staff. In the past, Resident #2 had been a "1 person assist" with regard to transfers and ambulation.
-She had planned to increase Resident #2 to a "two person assist" on the care plan next week during the care plan meeting.
-This was a change in condition based on staff reports by the PCAs, that she was no longer able to provide as much assistance when 1 person transferred her, especially with her leg injury.
-She was responsible for completing resident care plans.

Interviews with 15 other staff including PCAs and MAs revealed:
-They had all worked in the unit in which Resident #2 resided between 01/01/19 and 01/03/19 on 1st, 2nd, and 3rd shifts.
-No accidents involving Resident #2 had been reported to any of them by other staff members.
-No one was aware of the bruising and swelling on Resident #2's leg before they physical therapist identified it on 01/03/19.
-Over the past "month or so" Resident #2 had become weaker and was less able to "help" during transfers and when standing her up. Resident #2 was no longer able to pivot.
-Resident #2 used to try to get up, but for several months was no longer attempting to try to get up without assistance.
-Resident #2 would "never" be able to get up without assistance if she had fallen on the floor.
-When Resident #2 needed help with anything she would yell "help!" very loudly.
-Resident #2 did not have any chronic pain issues, so for her to be in pain was abnormal. Resident #2 had continued to exhibit symptoms of pain since returning from the hospital.
-Several staff had noticed the bruising after it was

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	HAL060108	A. BUILDING: _____ B. WING _____	01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN IN HIGHLAND CREEK	5920 MCCHESNEY DRIVE CHARLOTTE, NC 28269

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D914	Continued From page 52	D914		

identified by PT and asked other shifts if anyone knew what had happened to Resident #2, but no one was aware of an accident that could have caused the bruising and swelling on her leg.
-When an incident or fall occurred with a resident, staff were to immediately notify the MA so that the resident could be assessed.

Telephone interview with Resident #2's responsible party (RP) on 01/10/19 at 2:17pm revealed:
-She had visited Resident #2 on 01/03/19 for lunch and the WC told her at that time that they had observed some bruising on her leg that morning where she had "bumped" it on something.
-Staff did not know exactly what had caused the bruising.
-On the morning of 01/04/19, she received a call from the facility notifying her that the bruising had "spread" and that they were going to send Resident #2 out for an x-ray to assure she had no broken bones.
-She had not looked at the bruising on Resident #2.

Telephone interview with Resident #2's physician on 01/10/19 at 2:40pm revealed:
-He had not assessed Resident #2's leg, but if the bruising and swelling was on only one side of her body, and if the hospital report reflected a diagnosis of a contusion to the knee, some type of traumatic event would be suspected.
-The facility had notified him that Resident #2 had been sent to the hospital for evaluation for bruising from the hip to the knee.

Interview with Resident #2's physician's assistant on 01/10/19 at 4:20pm revealed:
-She was newly assigned to the facility and she

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D914	Continued From page 53	D914		

had never assessed Resident #2.
-There would have to be a traumatic event to cause bruising and swelling to Resident #2's leg.
-Coumadin may result in worsening bruising, but it would not cause spontaneous bruising.

Review of the facility's incident/accident reporting process policy revealed:
-"An incident/accident will be handled in a manner to promote the safety and health of individual(s) involved. Documentation will occur as soon as the situation has been stabilized and secure and not more than 24 hours after the occurrence, with an internal investigation to follow if indicated ..."
-An incident/accident is defined as being "any event that is not consistent with routine client care and services as defined by the company. Any event reportable to state agencies as defined by those agencies. Any event involving a client with unintended, undesirable or unexpected results or outcome."
-Documentation of incidents/accidents included a list of examples that were considered "serious in nature and thus require the completion of a written incident/accident report" the list included falls and "client injury of unknown origin (bruising, lacerations, etc)."
-Procedures when an incident/accident occurs included: "evaluate the situation, ensure client safety, summon assistance if necessary, and initiate first aid and/or emergency transfer to hospital."
-Examples of emergency situations that require intervention/treatment in an acute setting included "suspected fractures."
-Proper notification of incidents/accidents included: "Employee will notify the Clinical Director/Nurse Supervisor, family/responsible party will be notified, clinical director/nurse supervisor will notify agency administrator, and

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D914	Continued From page 54 executive director, employee will complete incident/accident report." Interview with Administrator on 01/10/19 at 4:40pm revealed: -She was aware that Resident #2 had been sent out for evaluation on 01/04/19 for bruising on the elbow and leg. -No staff were aware of Resident #2 having an incident prior to the bruising being identified. -At the time Resident #2 was sent out, she had told the RCD that an investigation needed be launched to determine how the resident became injured. -When Resident #2 returned later that day, the RCD had informed her that the hospital documentation reflected that the bruising was a result of Resident #2's coumadin therapy, so they did not pursue conducting an investigation, or reporting to the Health Care Personnel Registry (HCPR) as they felt it was no longer "an injury of unknown origin." -The expectation was that an incident report would be completed at the time any injury was identified, before the end of that shift by the PCA and the MA on duty. -She did not know why the WC had not completed an incident report at the time she and the PT had identified the injury. -It was the RCD's responsibility to launch an investigation anytime there was an injury of unknown origin and to report to HCPR. -The LHPS nurse would assist the RCD with any investigations and reporting to HCPR. The facility failed to assure 1 of 5 residents (Resident #2) was free from neglect, as a result of staff not seeking medical evaluation and treatment for an injury which was first identified by the Resident's physical therapist. The failure of	D914		

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D914	Continued From page 55 the facility to seek medical treatment put Resident #2 at risk of further severe injury and pain. These failures constitute a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/10/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 9, 2019.	D914		