STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060162	A. BUILDING: _____ B. WING _____	04/17/2024

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
D 000	Initial Comments The Adult Care Licensure Section and Mecklenburg County Department of Social Services conducted an annual survey on April 16, 2024-April 17, 2024.	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 interviews and record reviews, the facility failed to ensure medications were administered as prescribed for 1 of 5 sampled residents (Resident #3) related to a medication used to control elevated blood sugar. The findings are: Review of Resident #3's current FL2 dated 03/14/24 revealed: -Diagnoses included Type 2 diabetes and stage 3 kidney disease. -There was an order to check Resident #3's finger stick blood sugar (FSBS) before meals and at bedtime. -There was an order for insulin lispro 100 units/ml (a rapid acting insulin to lower elevated blood sugar levels) inject before meals and at bedtime per sliding scale: FSBS 60-149 = 0 units, 150-200 = 3 units, 201-250 = 5 units, 251-300 = 8 units,	D 358	The following is the Plan of Correction for The Haven in Highland Creek regarding the Corrective Action Report dated 4/17/24. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Nester TITLE: ED/ Administrator (X6) DATE: 5/17/24

Reviewed and Acknowledged by Susan McClendon 5/23/24

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D 358	Continued From page 1 301-350 = 10 units, 351-400 = 15 units, 401-450 = 18 units, 451-500 = 20 units, contact Primary Care Provider (PCP) for FSBS greater than 500 and hold insulin for FSBS less than 60. Review of Resident #3's PCP orders dated 11/06/23 and 03/21/23 revealed: -There was an order to check Resident #3's FSBS before meals and at bedtime. -There was an order for insulin lispro 100 units/ml inject before meals and at bedtime per sliding scale: FSBS 60-149 = 0 units, 150-200 = 3 units, 201-250 = 5 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 15 units, 401-450 = 18 units, 451-500 = 20 units, contact PCP for FSBS greater than 500 and hold insulin for FSBS less than 60. Review of Resident #3's February 2024 Medication Administration Record (MAR) revealed: -There was an entry to check FSBS before meals and at bedtime at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was an entry for insulin lispro 100 units/ml inject before meals and at bedtime per sliding scale: FSBS 60-149 = 0 units, 150-200 = 3 units, 201-250 = 5 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 15 units, 401-450 = 18 units, 451-500 = 20 units, contact PCP for FSBS greater than 500 and hold insulin for FSBS less than 60 at 7:30am, 11:30am, 4:30pm and 8:00pm. -On 02/22/24 at 4:30pm, the resident's FSBS was 261 and he received 3 units of insulin lispro when the order stated he should have received 8 units. -On 02/27/24 at 8:00pm, the resident's FSBS was 318 and he received 3 units of insulin lispro when the order stated he should have received 10 units.	D 358	10A NCAC 13F .1004(a) Medication Administration Provided training on medication administration process educating medication aides on how to properly administer sliding scale insulin. 4/26/24 Additional education on sliding scale and order processing system completed on 5/16/24 ADRC/and or designee to perform weekly MAR audits to confirm accuracy sliding scale administration 5/31/24 MD	

Melissa Nelson, ED 5/1/24

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Review of Resident #3's March 2024 MAR revealed:
-There was an entry to check FSBS before meals and at bedtime at 7:30am, 11:30am, 4:30pm and 8:00pm.
-There was an entry for insulin lispro 100 units/ml inject before meals and at bedtime per sliding scale: FSBS 60-149 = 0 units, 150-200 = 3 units, 201-250 = 5 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 15 units, 401-450 = 18 units, 451-500 = 20 units, contact PCP for FSBS greater than 500 and hold insulin for FSBS less than 60 at 7:30am, 11:30am, 4:30pm and 8:00pm.
-On 03/21/24 at 4:30pm, the resident's FSBS was 226 and he received 3 units of insulin lispro when the order stated he should have received 5 units.

Review of Resident #3's April 2024 MAR revealed:
-There was an entry to check FSBS before meals and at bedtime at 7:30am, 11:30am, 4:30pm and 8:00pm.
-There was an entry for insulin lispro 100 units/ml inject before meals and at bedtime per sliding scale: FSBS 60-149 = 0 units, 150-200 = 3 units, 201-250 = 5 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 15 units, 401-450 = 18 units, 451-500 = 20 units, contact PCP for FSBS greater than 500 and hold insulin for FSBS less than 60 at 7:30am, 11:30am, 4:30pm and 8:00pm.
-On 04/10/24 at 4:30pm, the resident's FSBS was 199 and he received 0 units of insulin lispro when the order stated he should have received 3 units.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 04/17/24 at 2:57pm revealed:

Melissa Nester, ED 5/17/24

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-Resident #3 had an order for insulin lispro 100 units/ml inject before meals and at bedtime per sliding scale: FSBS 60-149 = 0 units, 150-200 = 3 units, 201-250 = 5 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 15 units, 401-450 = 18 units, 451-500 = 20 units, contact PCP for FSBS greater than 500 and hold insulin for FSBS less than 60.
-Insulin lowered blood sugar levels and if the resident received less than the ordered amount, his blood sugar levels could remain elevated.
-High blood sugar levels could cause increased thirst and increased urination.

Interview with a medication aide (MA) on 04/17/24 at 1:10pm revealed:
-She was trained by a corporate nurse on insulin administration and how to properly document when she was hired.
-Resident #3 had an order for sliding scale insulin which included performing a FSBS and reading the MAR to determine the amount of insulin to administer based on the FSBS results.
-The MAs were responsible to accurately document the FSBS and the amount of insulin administered.
-She did not know if there were any audits of the MARs to determine if the sliding scale insulin was administered correctly to Resident #3.

Interview with the Memory Care Coordinator (MCC) on 04/17/24 at 1:56pm revealed:
-MAs were trained upon hire by another MA how to document medication administration on the paper MARs.
-The MAs were responsible to accurately administer medications and document the administration on the residents' MARs.
-The MAs were responsible to audit the MARs daily to ensure medications were administered as

Melissa Foster 5/17/24

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ordered.
-He was not aware of any instances Resident #3's received the wrong dose of sliding scale insulin.

Interview with the Executive Director (ED) on 04/17/24 at 2:57pm revealed:
-The MAs were responsible for accurately administering resident medications and documenting the administration on the MAR.
-The MAs were responsible for auditing resident MARs for accuracy, but she was unsure how frequently the audits were done.
-She was not aware there were times Resident #3 received the wrong dose of sliding scale insulin.

Melissa Nesta 5/07/24