Received 10/30/24

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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 09/10/24.	C 000	In regards to 10A NCAC 13G. 0802 (a) Resident Care Plan The administrator contacted the PCP for the resident and a signed care plan was faxed to the facility and placed in the resident's record. A review of all residents records was conducted to ensure that all required documentation was in the residents records. The administrator will audit resident records on a quarterly basis to ensure that all required documentation is in the resident record. Additionally, the facility will ensure that the care plan for a resident is done within 30 days of the admission of a resident and is maintained in the resident record.	9/10/24 9/10/24 and ongoing
C 236	10A NCAC 13G .0802 (a) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plans (a) A family care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan shall be an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#2) had a care plan completed within 30 days of admission. The findings are: Review of Resident #2's current FL2 dated 11/15/23 revealed: -Diagnoses included history of a stroke, auditory hallucinations and dysphagia. -Resident #2 had been hospitalized from 10/06/23 through 11/21/24 with a discharge plan to a domiciliary facility. -He was ambulatory. -He was continent of bowel and bladder. -He had intermittent disorientation. Review of Resident #2's Resident Register revealed he was admitted to the facility from the hospital on 11/21/24. Review of Resident #2's care plans revealed there was no care plan available for review.	C 236		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather B. Wilkins	Owner/Administrator	10/23/24

Received and acknowledged 10/30/24 C. Harrison for Sheryl Dair

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C 236	Continued From page 1 A copy of Resident #2's current care plan was requested from the medication aide/Supervisor-in-Charge (MA/SIC) on 09/10/24 at 10:16am but was not provided. Interview with Resident #2 on 09/10/24 at 11:23am revealed: -He was independent with eating, ambulating, transferring, toileting, bathing, and personal hygiene. -Staff helped him with his medications. Interview with a MA/SIC on 09/10/24 at 11:26am revealed: -Resident #2 was independent with his personal care but she made his meals and prepared and administered his medications. -She was not responsible for preparing or scheduling care plan assessments. Interview with the Administrator on 09/10/24 at 1:45pm revealed: -She was responsible for ensuring all residents had a care plan upon admission. -She was aware that Resident #2 might not have a current care plan because she had a hard time establishing him with a PCP after he was admitted to the facility. -She had not audited the resident records since May 2024. -She had not noticed that Resident #2 needed a care plan in his record; it was overlooked. Attempted telephone interview with Resident #2's primary care provider (PCP) on 09/10/24 at 1:35pm was unsuccessful.	C 236		

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C 254	Continued From page 2	C 254		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed quarterly for 1 of 3 sampled residents (#2) who had an LHPS task of fingerstick blood sugar (FSBS) checks. The findings are: Review of Resident #2's current FL2 dated	C 254	In Regards to 10A NCAC 13G .0903(C) Licensed Health Professional Support The facility contacted the LHPS nurse for the facility and the nurse completed a LHPS assessment on the resident. The administrator also audited other residents tasks to ensure that anyone needed a LHPS assessment was completed. The administrator will make sure that the LHPS nurse is contacted on quarterly basis to ensure that all residents requiring a LHPS task are assessed in accordance with state regulations. Also that new residents are assessed in 30 days upon admission or the onset of a task.	9/11/24 9/11/24 and ongoing

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C 254	Continued From page 3 11/15/23 revealed diagnoses included history of stroke, dysphagia, and auditory hallucinations. Review of Resident #2's signed physician's order dated 04/09/24 revealed an order for FSBS checks twice daily. Review of Resident #2's LHPS evaluations on 09/10/24 revealed there were no LHPS evaluations available for review. A copy of Resident #2's LHPS evaluation was requested from the medication aide/Supervisor-in-Charge (MA/SIC) on 09/10/24 at 10:16am and was not provided. Review of Resident #2's July 2024 medication administration record (MAR) revealed: -There was an entry for FSBS checks twice daily scheduled at 8:00am and 8:00pm. -There was documentation Resident #2's FSBS was checked twice daily from 07/01/24 through 07/31/24. -Resident #2's FSBS values ranged from 111 to 218. Review of Resident #2's August 2024 MAR revealed: -There was an entry for FSBS checks twice daily scheduled at 8:00am and 8:00pm. -There was documentation Resident #2's FSBS was checked twice daily from 08/01/24 through 08/31/24. -Resident #2's FSBS values ranged from 82 to 198. Review of Resident #2's September 2024 MAR from 09/01/24 through 09/10/24 revealed: -There was an entry for FSBS checks twice daily scheduled at 8:00am and 8:00pm.	C 254		

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C 254	Continued From page 4 -There was documentation Resident #2's FSBS was checked twice daily from 09/01/24 through 09/10/24. -Resident #2's FSBS values ranged from 106 to 179. Interview with Resident #2 on 09/10/24 at 11:23am revealed the staff checked his FSBS twice daily. Interview with a MA/SIC on 09/10/24 at 11:26am revealed: -She checked Resident #2's FSBS twice daily as ordered. -She was not responsible for preparing or scheduling LHPS assessments with the facility's LHPS nurse. Telephone interview with the facility's contracted LHPS nurse on 09/10/24 at 2:11pm revealed he was not familiar with Resident #2 and had not completed any LHPS evaluations for him. Interview with the Administrator on 09/10/24 at 3:30pm revealed: -She was not aware Resident #2 had an LHPS task and no LHPS evaluation available for review. -She was responsible for ensuring all residents with LHPS tasks had LHPS evaluations. -She had not audited the resident records since May 2024.	C 254		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:	C 342	In regards to 10A NCAC 13G .1004(j) Medication Administration	

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C 342	Continued From page 5 (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 the accuracy of the medication administration record (MAR) for 1 of 3 sampled residents (#2) related to documentation of a laxative medication. The findings are: Review of Resident #2's current FL2 dated 11/15/23 revealed diagnoses included history of stroke, dysphagia, and auditory hallucinations. Review of Resident #2's physician's order dated 08/19/24 revealed an order for Miralax (an osmotic laxative medication used to treat constipation) 17 grams (g) daily in 8 ounces (oz) of water or other non-carbonated beverage. Review of Resident #2's August 2024 MAR revealed:	C 342	The administrator audited residents MARs to ensure that all medication present with orders are maintained correctly on the residents MARS Any medication not listed in which there are orders for and the medication present, the SIC will write the order onto the MAR. Any new orders received directly from the physician will be forwarded to the contracted pharmacy to include on the MAR. The Medication Aide will review MAR each month to ensure that all ordered medication is listed and checked against medication supply. The Medication Aide will inform the pharmacy of the error and will then write the missing medication onto the MAR. The Administrator or designee will review the MAR and medications monthly to ensure compliance.	9/10/24 9/10/24 and ongoing

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C 342	Continued From page 6 -There was an entry for Miralax 17g in 8oz water daily scheduled at 8:00am. -There was documentation Miralax was administered daily from 08/22/24 through 08/31/24. Review of Resident #2's September 2024 MAR from 09/01/24 through 09/10/24 revealed there was no entry for Miralax 17g daily or documentation that Miralax had been administered from 09/01/24 through 09/10/24. Observation of medications on hand for Resident #2 on 09/10/24 at 11:25am revealed there was one half-full 510g container of Miralax powder with a dispensed date of 08/21/24. Interview with Resident #2 on 09/10/24 at 11:23am revealed: -He received Miralax in his water every day. -The medication aide (MA) always poured the Miralax powder into his water in front of him. -He had not missed a day of receiving Miralax since he started taking it last month, August 2024. Interview with the MA/Supervisor-in-Charge (SIC) on 09/10/24 at 11:26am revealed: -Resident #2 had a current order for Miralax daily. -She administered Miralax to Resident #2 daily as ordered. -She had not noticed that there was no entry for Resident #2's September 2024 MAR to document the administration of Miralax. -She had hand-written the entry for Miralax on Resident #2's August 2024 MAR when the order had been written. -The pharmacy printed the facility's MARs and sent them to the facility each month. -She usually checked the MARs each month	C 342		

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C 342	Continued From page 7 when the pharmacy sent them to make sure the medications were correct, but she had not noticed that Resident #2's September 2024 MAR did not have Miralax on it. Telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:42pm revealed: -Resident #2 had a current order dated 08/19/24 for Miralax 17g daily. -The pharmacy dispensed one container of Miralax for Resident #2 on 08/21/24, and one container was a 30-day supply. -The facility's staff would have needed to write the Miralax entry on his August 2024 MAR since it was a new order written for that month. -The pharmacy had already printed Resident #2's September MARs by the time they received his Miralax order, so that was why the MAR did not have an entry for Miralax in September 2024 either. -Someone at the facility would have been responsible for checking the medication entries on the MAR and handwriting an entry for Miralax. Interview with the Administrator on 09/10/24 at 3:30pm revealed: -The MA was responsible to check the MARs from the pharmacy each month to ensure they were accurate. -She expected the MAs to document every medication they administered. -She expected the MAs to contact the pharmacy to request a MAR sheet containing new medication orders rather than the MAs writing in a medication order entry on the MAR. -The pharmacy should have sent the facility an updated September 2024 MAR for Resident #2 which included an entry for Miralax, but the MAs should have noticed there was nowhere to	C 342		

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C 342	Continued From page 8 document that they had administered Resident #2's Miralax. Attempted telephone interview with the facility's second MA/SIC on 09/10/24 at 1:25pm was unsuccessful.	C 342		