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

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D 000	Initial Comments The Adult Care Licensure Section and Mecklenburg County Department of Social Services conducted a complaint investigation on April 11, 2025-April 16, 2025. The Mecklenburg County Department of Social Services initiated the complaint on March 21, 2025.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to provide supervision for 2 of 10 sampled residents (Resident #3 & #7) related to a resident who had increased aggressive and wandering behaviors (#3) and a resident who was newly admitted to the facility with exit seeking behaviors that sustained a head injury after a fall (#7). The findings are: Review of the facility's Fall Management and Investigating policy dated 03/19/24 revealed: -A fall was defined as an "unplanned decent to	D 270		

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the floor with or without injury to the resident".
-All residents were to have a fall risk assessment completed upon admission.
-If the score on the fall risk assessment indicated a fall risk, it may prompt a referral for a rehabilitation consultation.
-After the resident experienced a fall, their service plan/care plan was to be reviewed and revised.
-The changes made to the service plan/care plan were to be communicated to the staff, resident, and family.
-Fall interventions were to be reviewed for continued effectiveness.
-Fall interventions were to be communicated to staff, family and resident for safety awareness and the risk and benefits of fall prevention.
-Falls were to be investigated, reported, and documented, using root cause analysis concepts.
-The Administrator was responsible for instituting/commencing the investigation process.
-The Resident Care Director (RCD), or designee, was to analyze the results for trends and patterns in resident falls to use as the basis for implementation of process improvement.

Review of the facility's license revealed the license was effective 01/01/25 through 12/31/25 for a capacity of 60 special care unit (SCU) residents.

Observation of the facility on 04/11/25 between 6:00am to 7:00pm revealed:
-The entry into the facility was through the front locked door.
-The front entry included a reception area and three offices with locked doors.
-The back hall of the entry included two guest bathrooms, an employee training room and another office.
-There was a locked door to the main common

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area known as "Main Street" which included a "soda shop" for activities and gatherings, two locked offices, a locked beauty shop, a locked medication room/nurses' station, a locked central laundry room, and 3 locked hallways to the left, middle and right of the main common area.

Review of Resident #3's current FL2 dated 10/08/24 revealed:
-Diagnoses included dementia, Alzheimer's disease and hypertension.
-She was ambulatory.
-She was incontinent of bowel and bladder.
-Her level of care was a Special Care Unit (SCU).

Review of Resident #3's current care plan dated 02/12/25 revealed:
-She required supervision with ambulation.
-She required limited assistance with eating and transfers.
-She was totally dependent with toileting, bathing, dressing and grooming.

Attempted telephone interviews with Resident #3's Power of Attorney (POA) on 04/07/25 at 1:33pm and on 04/11/25 at 8:45am were unsuccessful.

a. Review of the facility's 24-Hour Health Care Personnel Registry (HCPR) investigation report dated 03/24/25 revealed:
-On 03/21/25, the Administrator was notified via email from another resident's family member that Resident #3 was observed to have been left alone by a staff member in the main common area of the facility known as "Main Street" with all of doors to the hallways locked.
-The incident happened on 03/19/25 at 8:00pm.
-The initial discussion with a medication aide (MA) revealed Resident #3 was left alone in the

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main common area with all the doors leading to the residents' rooms locked, and staff checked on her frequently.

Review of the facility's 5-day HCPR investigation report dated 03/26/25 revealed:
-On 03/19/25, Resident #3 was placed in the main common area known as "Main Street" by a MA and was left unattended.
-The MA placed Resident #3 outside of the residents' hallway in the main common area (still behind locked doors) without supervision instead of reaching out to the supervisor or other staff for assistance because the resident was agitating other residents.
-"It appeared" Resident #3 was locked in the main common area, with the door locked to the 3 hallways to the residents rooms, without supervision for about an hour before another staff working on a different hall than Resident #3 resided heard Resident #3 knocking on the hallway's doors.
-The facility was fully staffed and there were other staff to call on the walkie talkie for assistance per the protocol.

Review of Resident #3's March 2025 Activities of Daily Living (ADL) logbook revealed there were no entries or documentation for increased supervision after the resident's increased behaviors on 03/19/25.

Review of Resident #3's March 2025 progress notes revealed:
-On 03/03/25, a MA documented during personal care assistance, Resident #3 started yelling, screaming and struck her and the other staff assisting.
-On 03/19/25 at 2:47pm, a MA documented Resident #3 hit another resident on the shoulder

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and stated that Resident #3 was going to punch the other resident and both residents were separated.
-On 03/20/25, the MA documented Resident #3 was pacing around the hallway and going into other resident's rooms and upsetting the other residents, so to avoid agitations, staff walked Resident #3 off of the hallway so she could walk around about 7:45pm to 8:00pm.
-On 03/22/25 at 11:50pm, the MA documented Resident #3 was ambulating outside of the hallway to prevent Resident #3 from going into other residents' rooms.
-On 03/23/25 at 6:33am, the MA documented Resident #3 did not sleep all shift and continued going into other residents' rooms and was sent to main common area.
-On 03/23/25 at 6:33am, the MA documented "until 6:00am" Resident #3 was "still wandering around."

Request for additional documents for Resident #3 related to her increased behaviors on 03/19/25 were made on 04/11/25 at 1:10pm and on 04/14/25 at 9:00am were not provided by survey exit date.

Interview with another resident's family member on 03/25/24 at 6:30pm revealed:
-On 03/19/25, while he was visiting his family member, there was only one personal care aide (PCA) working on Resident #3's hallway on second shift (3:00pm-11:00pm) and a MA that was floating between all three hallways.
-He was there late in the evening that night because there was only one staff working.
-Resident #3 started "stirring up" another resident and he observed the staff member place Resident #3 behind the closed locked door outside the unit in the common area, without

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supervision, so that she could provide care for all the other residents.
-All the 3 hallway doors leading from the main common area known as "Main Street" were usually locked in the evening after dinner.
-When he was ready to leave, the MA let him out of the hallway that his family member lived on into the main common area.
-A PCA came out of another hallway to let him out of the main locked doors of the facility.
-While in the main common area, he observed Resident #3 wandering around alone, with no supervision, trying to open closed doors and windows.
-He was unsure how long Resident #3 had been in the common area.
-On 03/21/25, he expressed his concerns about this situation to the Administrator.

Telephone interview with a PCA on 04/15/25 at 11:23am revealed:
-A few weeks ago, she was working 2nd shift in the hallway where Resident #3 resided.
-She was working on the hallway alone at the time because the assigned MA was on another hallway.
-Resident #3 was going in and out of other residents' rooms and was agitating other residents and got into an altercation with a resident who had recently returned from the hospital.
-Resident #3 was wandering around the hallway and the other resident wanted her to sit down and was trying to help her do so, which agitated Resident #3 even more.
-To keep the situation from escalating, she allowed Resident #3 to exit the hallway into the main common area and closed the locked door.
-This was not the first time the main common area had been used for residents who had

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aggressive behaviors or wanted to wander.
-She observed many other staff put residents out in the main common area to allow them to calm down and decrease behaviors when they were agitated.
-The Assistant Health and Wellness Director (HWD) was also aware the main common area was used by staff to manage agitated residents and he directed staff to put residents in the main common area.
-Sometimes the Assistant HWD would come into the hallway and ask why a resident was restricted to the main common area, but he never told staff they were not allowed to lock residents out of the hallway.
-Residents were placed in main common area unsupervised "many times" late on second shift when the doors to the hallways were locked and there were no staff on the main common area to supervise the residents.

Interview with a (MA) on 04/16/25 at 4:12pm revealed;
-Resident #3 was combative during personal care and did not follow commands.
-The other residents would get upset when Resident #3 would wander into their rooms and she would have to try to redirect Resident #3.
-When Resident #3 displayed agitation, wandering into other resident's rooms, and "out of control" behaviors, it was not uncommon to place Resident #3 out in the main common area so that Resident #3 could calm down.
-When Resident #3 was out in the main common area after about 7:00pm, Resident #3 did not have any supervision.
-On 03/19/25, she was working on another hallway when a PCA placed Resident #3 in the main common area without supervision for about an hour or so and the PCA did not call her on the

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walkie talkie for assistance.
-The facility did not have enough staff to provide "one on one" supervision.
-Placing Resident #3 in the main common area was the easiest way to let Resident #3 calm down.
-There was no way to supervise Resident #3 when Resident #3 was locked out of her hallway and the other two hallways or to even know what Resident #3 was doing during the time she was out in the main common area.

Attempted telephone interview with another MA on 04/16/25 at 4:25pm and 5:30pm was unsuccessful.

Interview with the Administrator on 03/21/25 at 9:45am revealed:
-She recently learned Resident #3 was locked on the main common area because she was trying to "help" another resident, and it was aggravating the other resident.
-As the situation continued to escalate, the PCA made the decision to walk Resident #3 to the main common area, leave Resident #3 unsupervised, and lock the door to the hallway where Resident #3 lived.
-Resident #3 "liked to wander" so she felt the PCA had acted appropriately.
-She did not have any concerns about Resident #3 being in the main common area known as "Main Street" unsupervised because "they go out there all the time."

Refer to interview with a MA on 04/01/25 at 1:20pm.

Refer to telephone interview with Resident #3's Psychiatrist on 04/16/25 at 3:30pm.

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D 270	Continued From page 8 Refer to interview with the Administrator on 04/01/25 at 3:45am. b. Review of Resident #3's accident/incident (A/I) report dated 04/01/25 at 2:40pm revealed: -Resident #3 was witnessed attempting to strike another resident. -Resident #3 pushed another resident's walker into them while they were sitting in the living room. -A third resident blocked Resident #3 from striking the second resident. -Resident #3 started shaking the third resident forcefully and struck the third resident two times. -Staff intervened and separated all residents involved. -There were no injuries documented. -The initial physiological risk factors that could have contributed to the behaviors were documented as confusion and impaired memory. -There were no post-incident environmental or situational risk factors that could have contributed to the increased behaviors documented on the report. -Staff notified Resident #3's POA and Primary Care Physician (PCP). -The Assistant Health and Wellness Director (HWD) completed the report. Request for additional documents for Resident #3 related to her increased aggressive behaviors on 04/01//25 were made on 04/11/25 at 1:10pm and on 04/14/25 at 9:00am were not provided by survey exit date. Refer to interview with a MA on 04/01/25 at 1:20pm. Refer to telephone interview with Resident #3's Psychiatrist on 04/16/25 at 3:30pm.	D 270		

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D 270	Continued From page 9 Refer to interview with the Administrator on 04/01/25 at 3:45am. _____ Interview with a MA on 04/01/25 at 1:20pm revealed: -Management instructed staff to try to redirect Resident #3 when she exhibited behaviors. -Resident #3 was "known" for her behaviors and frequently required 2-3 staff to assist with dressing, toileting and bathing. -She found that trying to distract Resident #3 from using her hands by clapping or giving her something to hold sometimes helped during personal care; she also would ask other staff members to attempt care if Resident #3 was uncooperative and sometimes that worked. -One strategy management had told them to try was to refer to her as "Nurse" and tell her it was "time to check on her patients" because she was a former nurse. -There were no instructions to increase more frequent checks on Resident #3. Telephone interview with Resident #3's Psychiatrist on 04/16/25 at 3:30pm revealed: -Resident #3 was last seen on 04/04/25 and staff reported Resident #3 was kicking staff. -Resident #3 was displaying increased behaviors and there was a discussion to admit Resident #3 to the Psychiatric unit for monitoring. -After a conversation with the family, he decided to add a medication to help with behaviors which would allow Resident #3 to remain at the facility with increased monitoring for about 1-2 more weeks while the new medication took effect. -He told the Assistant HWD to increase monitoring, and if the behaviors continued to be out of control, they would arrange for admission to the hospital for increased monitoring and other	D 270		

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medication changes until Resident #3 was stable.
-Resident #3 required 24/7 supervision and that was why Resident #3 resided in the Special Care Unit.
-When Resident #3 was left unsupervised, the risk of impulsivity increased for Resident #3 which, if left unchecked, could lead to her getting scared, causing her to fall and possibly sustain an injury.
-Because Resident #3 was unsteady on her feet, if left unsupervised, that increased the risk of a fall with an injury, which could lead to a delay in emergency care.

Interview with the Administrator on 04/01/25 at 3:45am revealed:
-She had looked into the incident regarding Resident #3 being locked in the main common area alone recently and determined she did not initially have all the information about the situation.
-She was not aware that the doors to the other units were locked and there were no staff in the common area in which Resident #3 was placed.

2. Review of Resident #7's current FL-2 dated 03/11/25 revealed:
-Diagnoses included Alzheimer's/dementia, atrial fibrillation, and neuritis of lower extremity (a common nerve disorder involving inflammation of a nerve or group of nerves).
-He was constantly disoriented, ambulatory and was continent of bowel and bladder.
-His level of care was SCU.

Review of Resident #7's Resident Register revealed he was admitted to the facility on 03/03/25.

Review of Resident #7's care plan dated 04/08/25

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revealed:
-He required supervision in the facility due to wandering and elopement behaviors.
-He required extensive regular supervision in the facility and could not be left unattended.
-He required his caregivers to observe his location to prevent exit seeking behaviors, and to prevent him from entering other residents rooms.
-He required a safe environment that was clutter free.
-He was able to ambulate independently.
-He required standby assistance with dressing and physical assistant with bathing and grooming but could participate in the activity.

Telephone interview with Resident #7's Responsible Party on 04/16/25 at 9:32am revealed:
-Resident #7 had temporal lobe dementia (an umbrella term used to describe a group of brain diseases that mainly affect the areas of the brain associated with personality, behavior and language).
-Resident #7 was not familiar with his new surroundings and was "out of his element, and this was not normal behavior for him".
-She was made aware of Resident #7's fall on 03/19/25.

Observation on 04/15/25 at 11:35am of Resident #7 revealed:
-He was walking through the main area of the facility looking at the outdoors.
-He paced around the halls and walked at a faster pace.

Review of Resident #7's accident/incident (A/I) report dated 03/19/25 revealed:
-Resident #7 had a fall at 11:35am.
-He was walking out of his room, turned the

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wrong way and lost his balance and fell face down in the hallway.
-His forehead was bleeding which stopped after 30 seconds.
-He had an abrasion on his face.
-Staff intervened, vital signs were taken, EMS was called and Resident #7 was taken to the hospital.
-Physiological risk factors were confusion, impaired memory, and gait imbalance.
-Situational risks factors were ambulating without assistance and wandering behaviors.

Review of Resident #7's EMS report dated 03/19/25 at 11:35am revealed:
-A unit was dispatched at 11:43am for a resident who fell from standing.
-The unit arrived at the scene at 11:59am and Resident #7 was sitting on a chair.
-Resident #7 had a small laceration across his forehead.
-Resident #7 denied head and neck pain.
-Resident #7 was placed in a cervical collar (a medical device used to support a person's neck) due to cuts on his head and he struck his head on the floor.
-Resident #7 was taken to the hospital at 12:19pm.

Review of Resident #7's Emergency Department (ED) provider notes dated 03/19/25 revealed:
-Resident #7 presented to the ED for an evaluation after a ground level fall at his assisted living facility.
-Resident #7 sustained multiple small lacerations to his forehead.
-The report indicated nursing staff at the assisted living facility witnessed the fall and reported Resident #7 tripped on his feet striking his forehead.

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-Strict return precautions were provided regarding new or worsening symptoms such as change in mental status, worsened headache, or pain in other locations not described during Resident #7's visit.
-Resident #7 was discharged back to the facility on 03/19/25 at 4:18pm with a diagnosis of an abrasion of head, initial encounter.

Review of Resident #7's fall assessment dated 03/03/25 revealed:
-This was Resident #7's initial fall assessment completed upon admission.
-Resident #7 had not fallen in the last six months.
-Resident #7 did not require ambulatory aids.
-Resident #7 was aware of his limitations.
-Resident #7 fall risk interventions included staff to provide a safe environment that was clutter free, staff to become familiar with daily routine and to try to anticipate daily needs, and to ensure appropriately-fitting clothing and footwear were worn when ambulating.
-Resident #7 had a total score of 40 which indicated a moderate risk for falling (a score under 25 points was considered low risk for falls, 25-45 points considered moderate and greater than 45 points considered high risk).

Review of Resident #7's fall assessment dated 03/27/25 revealed:
-This was a fall assessment completed on 03/27/25 after Resident #7's fall on 03/19/25.
-Resident #7 had a history of falls in the last six months.
-Resident #7 did not require ambulatory aids.
-Resident #7 now overestimates or forgets his limitations.
-Resident #7 fall risk interventions included staff to provide a safe environment that was clutter free, staff to become familiar with daily routine

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and to try to anticipate daily needs, and to ensure appropriately-fitting clothing and footwear were worn when ambulating.
-Resident #7 had a total score of 80 which indicated a high risk of falling (a score under 25 points was considered low risk for falls, 25-45 points considered moderate and greater than 45 points considered high risk).

Review of Resident #7's March 2025 Activities of Daily Living (ADL) logbook revealed there were no entries or documentation for increased supervision after the resident's fall on 03/19/25.

Review of Resident #7's March 2025 progress notes revealed:
-There was no documentation of any interventions for increased supervision put in place after Resident #7's fall on 03/19/25.
-There were no entries or documentation on progress notes related to interventions, increased checks/supervision on the resident after his fall on 03/19/25.

Request for additional documents for Resident #7 related to his fall on 03/19/25 were made on 04/11/25 at 1:10pm and on 04/14/25 at 9:00am were not provided by survey exit date.

Interview with the Assistant HWD on 04/15/25 at 9:15am and 04/16/25 at 5:10pm revealed:
-He did not know if staff checked on Resident #7 more frequently after the resident fell on 03/19/25.
-He thought he completed a post fall assessment after Resident #7's fall on 03/19/25 but he could not locate it.
-After a resident had a fall, supervision was increased for the resident and staff ensure any items they may need are within reach.

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D 270	Continued From page 15 -Staff also ensured residents with recent falls were wearing proper footwear and their walker was within reach. -The MA was responsible for ensuring additional fall measures were implemented. -Typically, staff checked on residents after each meal, at the beginning of the shift and throughout the shift periodically. -On 3rd shift, staff checked on residents at the beginning of the shift, and they would conduct rounds every 1.5 - 2 hours. -Third shift was also responsible for washing and drying laundry and checking on residents throughout the shift as they return residents' laundry. -There were usually 3-4 staff members in the facility during 3rd shift. -Since there was one PCA assigned to each hallway on 3rd shift and a MA that floated between the hallways, the PCA in the hallway would call the MA to provide coverage to their unit while they were in the laundry room. Telephone interview with Resident #7's PCP on 04/16/25 at 11:47am revealed: -He was made aware of Resident #7's fall on 03/19/25. -He expected staff to monitor the Resident post fall for at least 24 hours. -For all head injuries, he expected the staff to increase supervision/monitoring for increased pain, changes in mental status, abnormal behaviors or increased confusion which could indicate a brain bleed which could be life threatening. -If the resident was not being monitored, symptoms such as confusion, or chance of a brain bleed could be missed if the Resident has sustained a head injury.	D 270		

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D 270	Continued From page 16 Interview with the Assistant HWD on 04/15/25 at 8:40am revealed: -After a fall, all staff were to supervise and monitor the resident, keep the resident's door open, monitor the resident's ambulation to make sure it is good/base line and keep all pathways clear. -After a fall, all staff were to observe the resident for any new bumps or bruising when changing their clothes, taking them to the restroom and for any issue that was different from their baseline. -New staff did not know the residents so "seasoned" staff were placed with new staff during their orientation until the new staff became familiar with the residents before the new staff were allowed to provide resident care on their own. -After a fall/incident, the MA was responsible for completing an A/I report. -After the fall/incident the resident who the fall/incident report was completed on was put in the "Hotbox" area for staff to report on to the next shift, monitor and document on every shift for 72-hours. -After a fall/incident, the MAs were responsible for every shift to document increased supervision for 72-hours, on the residents which included any new complaints or changes in the resident's baseline. Interview with the Assistant HWD on 04/16/25 at 5:10pm revealed: -He was responsible for reviewing the A/I Report and completed the post fall section, add any new interventions to the care plan and for the PCAs to the ADL book at the nurse's station. -The MAs were responsible to make sure supervision of the residents took place or were implemented. -The PCAs were responsible for reviewing the	D 270		

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Activities of Daily Living (ADL) book at the beginning of their shift.
-The MAs were responsible for giving report to the PCAs prior to the start of the shift in relation to increased supervision because of an accident/incident or as needed.
-After a concern/accident/incident, the MAs were responsible for placing the resident's record in the Hotbox area to remind them to report off to the PCAs at the beginning of every shift and to the MAs at the end of every shift, and to document on the resident every shift and continue to document every shift for the next 72-hours.
-The Supervising MA on each shift, and the HWD were responsible for reviewing all Hotbox documentation to make sure it was completed.
-He did not know the Hotbox documentation was not completed on the residents.

Interview with the HWD on 04/16/25 at 5:58pm revealed:
-The Supervising MA and MAs were responsible to complete the A/I report and to complete a shift progress note in the resident's record.
-The Assistant HWD was responsible for reviewing the A/I reports and progress notes daily to make sure they were completed.
-He was responsible for reviewing the A/I report and progress notes within 48-hours to make sure they were completed.
-Once the Assistant HWD received the A/I Report, the Assistant HWD was responsible for completing the post section of the report and then add the new interventions to the care plan and review the progress notes daily to make sure the MAs documented every shift for 72-hours.
-The Assistant HWD was also responsible to add the interventions to the ADL book at the nurse's station for the PCAs to review prior to the start of their shift.

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-The PCAs were responsible to give the MAs a report every shift of any issues or concerns about the residents.
-The MA were responsible to document increased supervision on every resident in the Hotbox every shift for 72-hours.
-The Assistant HWD was responsible for reporting to him daily any issues or concerns about the residents.
-He did not know the MAs were not checking on residents more frequently and not documenting on the residents in the Hotbox or the PCAs were not documenting or completing the task in the ADL book related to interventions.

Interview with the Administrator on 04/14/25 at 3:45pm revealed:
-After a fall residents should have increased supervision and resident should be put in the Hotbox for monitoring over the next 72-hours.
-MA's were responsible for documenting the resident and how they were doing every shift over the next 72-hours after a fall and as needed.
-She was not sure if PCA's should also document but documentation on the resident should be completed every shift.

Interview with the Administrator on 04/16/25 at 6:33pm revealed:
-After an incident or accident, the MAs were responsible for completing an A/I form.
-Once the A/I form was completed, the MAs were responsible every shift for 72-hours, they were to complete a progress note and give a shift report about the incident with details and any new interventions that were to be completed.
-The MAs were responsible to communicate those reports and interventions to the PCAs.
-Prior to 04/07/25, the PCAs were responsible to report any issues or concerns to the MAs and

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D 270	Continued From page 19 check off the interventions on their ADL sheets at the nurse's station. -The Assistant HWD was responsible to communicate the interventions to the MAs. -The HWD was responsible to complete monthly audits of the A/I Reports, progress notes and shift report every shift for 72-hours, and the PCAs documentation of the interventions in the ADL books. -She did not know the MAs and PCAs were not completing interventions to prevent falls and progress notes or reports on every A/I. -She did not know the HWD was not completing the audits. [Refer to Tag D0338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. [Refer to Tag D0468, 10A NCAC 13F .1309 Special Care Unit Staff Orientation and Training (Type A1 Violation)]. _____ The facility failed to ensure supervision of residents resulting in Resident #3 who had aggressive behaviors and was locked in the main common area by staff for up to an hour on more than one occasion leaving her out of the immediate view of staff without supervision. This put the resident at risk for increased anxiety, agitation, and injury and no staff to meet the resident's needs or respond in case of an accident or emergency. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/11/25 for this violation.	D 270		

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D 270	Continued From page 20 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 31, 2025.	D 270		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, record reviews, the facility failed to ensure 1 of 10 sampled residents who were treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy related to a resident who was locked in the common area of the facility when staff did not know how to manage her agitation (#3). The findings are: Review of the facility's license revealed the license was effective 01/01/25 through 12/31/25 for a capacity of 60 special care unit (SCU) residents. Observation of the facility on 04/11/25 from 6:00am to 7:00pm revealed: -The entry into the facility was through the front locked door. -The front entry included a reception area and three locked doors into offices.	D 338		

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-The back hall of the entry included two guest bathrooms, an employee training room and another office.
-There was a locked door to the main common area known as "Main Street" which included a "soda shop" for activities and gatherings, two locked offices, a locked beauty shop, a locked medication room/nurses' station, a locked central laundry room, and 3 locked hallways to the left, middle and right of the main common area.

Review of Resident #3's current FL2 dated 10/08/24 revealed:
-Diagnoses included dementia, Alzheimer's disease, and hypertension.
-She was ambulatory.
-She was incontinent of bowel and bladder.
-Her level of care was a Special Care Unit (SCU).

Review of Resident #3's current care plan dated 02/12/25 revealed:
-She required supervision with ambulation.
-She required limited assistance with eating and transfers.
-She was totally dependent with toileting, bathing, dressing and grooming.

Attempted telephone interviews with Resident #3's Power of Attorney (POA) on 04/07/25 at 1:33pm and on 04/11/25 at 8:45am were unsuccessful.

a. Review of the facility's 24-Hour Health Care Personnel Registry (HCPR) investigation report dated 03/24/25 revealed:
-On 03/21/25, the Administrator was notified via email from another resident's family member informing her that Resident #3 was observed to have been left alone in the main common area of the facility known as "Main Street" by a staff

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member with all of doors to the hallways locked.
-The incident happened on 03/19/25 at 8:00pm.
-The initial discussion with a medication aide (MA) revealed Resident #3 was left alone in the main common area with all the doors leading to the residents' rooms locked, and staff checked on her frequently.

Review of the facility's 5-day HCPR investigation report dated 03/26/25 revealed:
-On 03/19/25, Resident #3 was placed in the main common area known as "Main Street" by a medication aide (MA) and was left unattended.
-The MA placed Resident #3 outside of the residents' hallway in the main common area (still behind locked doors) without supervision instead of reaching out to the supervisor or other staff for assistance because the resident was agitating other residents.
-"It appeared" Resident #3 was locked in the main common area with the door locked to the 3 hallways to the residents rooms without supervision for about an hour before another staff working on a different hall than Resident #3 resided heard Resident #3 knocking on the hallway's doors.
-The facility was fully staffed and there were other staff to call on the walkie talkie for assistance per the protocol.

Review of Resident #3's March 2025 progress notes revealed:
-On 03/19/25 at 2:47pm, a MA documented Resident #3 hit another resident on the shoulder and stated that Resident #3 was going to punch the other resident and both residents were separated.
-On 03/20/25, the MA documented Resident #3 was pacing around the hallway and going into other resident's rooms and upsetting the other

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residents, so to avoid agitations, staff walked Resident #3 off of the hallway so she could walk around about 7:45pm to 8:00pm.
-On 03/22/25 at 11:50pm, the MA documented Resident #3 was ambulating outside of the hallway to prevent Resident #3 from going into other residents' rooms.
-On 03/23/25 at 6:33am, the MA documented Resident #3 did not sleep all shift and going into other residents' rooms and sent to main common area.
-On 03/23/25 at 6:33am, the MA documented "until 6:00am" Resident #3 was "still wandering around".

Interview with another resident's family member on 03/25/24 at 6:30pm revealed:
-On 03/19/25, while he was visiting his family member, there was only one personal care aide (PCA) working on Resident #3's hallway, on second shift (3:00pm-11:00pm) and a MA that was floating between all three hallways.
-He was there late in the evening that night because there was only one staff working.
-Resident #3 started "stirring up" another resident and observed the staff member put Resident #3 behind the closed locked door outside the unit in the common area, so that she could provide care for all the other residents.
-All three hallway doors leading from the main common area known as "Main Street" were usually locked in the evening after dinner.
-When he was ready to leave, the MA let him out of the hallway that his family member lived on into the main common area.
-A PCA came out of another hallway to let him out of the main locked doors of the facility.
-While in the main common area, he observed Resident #3 wandering around alone, with no supervision, trying to open closed doors and

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windows.
-He was unsure how long Resident #3 had been in the common area.
-On 03/21/25, he expressed his concerns about this situation to the Administrator.

Interview with the Administrator on 03/21/25 at 9:45am revealed:
-She recently learned Resident #3 was locked on the main common area because Resident #3 was trying to "help" another resident, and it was aggravating the other resident.
-As the situation continued to escalate, the PCA made the decision to walk Resident #3 to the main common area, leave Resident #3, and lock the door to the hallway where Resident #3 lived.
-Resident #3 "liked to wander" so she felt the PCA had acted appropriately.
-She did not have any concerns about Resident #3 being in the main common area known as "main street "unsupervised because "they go out there all the time."

Telephone interview with a PCA on 04/15/25 at 11:23am revealed:
-A few weeks ago, she was working 2nd shift in the hallway where Resident #3 resided.
-She was working on the hallway alone at the time because the assigned MA was on another hallway.
-Resident #3 was going in and out of other residents' rooms and was agitating other residents and got into an altercation with a resident who had recently returned from the hospital.
-Resident #3 was wandering around the hallway and the other resident wanted her to sit down and was trying to help her do so, which agitated her more.
-To keep the situation from escalating, she let

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Resident #3 exit the hallway into the main common area and closed the locked door.
-This was not the first time the main common area had been used for residents who had aggressive behaviors or wanted to wander.
-She observed many other staff put residents out in the main common area to allow them to calm down and decrease behaviors when they were agitated.
-The Assistant Health and Wellness Director (HWD) was also aware the main common area was used for agitated residents and he directed staff to put residents in the main common area.
-Sometimes the Assistant HWD would come into the hallway and ask why a resident was restricted to the main common area, but he never said staff were not allowed to lock residents out of the hallway.
-Residents were placed in main common area unsupervised many times late on second shift when the doors to the hallways were locked and there were no staff on the main common area to supervise the residents.

Interview with a medication aide (MA) on 04/16/25 at 4:12pm revealed;
-Resident #3 was combative during personal care and did not follow commands.
-The other residents would get upset when Resident #3 would wander into their rooms and she would have to try to redirect Resident #3.
-When Resident #3 displayed agitation, wandering into other resident's rooms, and "out of control" behaviors, it was not uncommon to place Resident #3 out in the main common area without supervision so that Resident #3 could calm down.
-When Resident #3 was out in the main common area after about 7:00pm, Resident #3 did not have any supervision.
-On 03/19/25, she was working on another

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

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hallway when a PCA placed Resident #3 in the main common area without supervision for about an hour or so and the PCA did not call her on the walkie talkie for assistance.
-The facility did not have enough staff to provide "one on one" supervision..
-Placing Resident #3 in the main common area was the easiest way to let Resident #3 calm down.
-There was no way to supervise Resident #3 when Resident #3 was locked out of her hallway and the other two hallways or to even know what Resident #3 was doing during the time she was out in the main common area.

Telephone interview with Resident #3's Psychiatrist on 04/16/25 at 3:30pm revealed:
-Resident #3 was last seen on 04/04/25 and staff reported Resident #3 was kicking staff.
-Resident #3 was displaying increased behaviors and a discussion was to admit Resident #3 to the hospital for monitoring.
-After a conversation with the family, he decided to add a medication to help with behaviors and would allow Resident #3 to remain at the facility with increased monitoring for about 1-2 more weeks while the new medication took effect.
-He told the Assistant HWD to increase monitoring, and if the behaviors continued to be out of control, notify him and they would arrange for admission to the hospital for increased monitoring and other medication changes until Resident #3 was stable.
-Resident #3 required 24/7 supervision and that was why Resident #3's level of care was a SCU.
-From 03/19/25 to 03/21/25, he did not know Resident #3 was left unsupervised for about an hour.
-When Resident #3 was left unsupervised, it increased the risk of impulsivity in Resident #3

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which, if left unchecked, could lead to getting scared, causing a fall and possibly an injury.
-Because Resident #3 was unsteady on her feet, if left unsupervised, there was an increased the risk of a fall with an injury, that could lead to a delay in emergency care.

Interview with the Assistant HWD on 04/15/25 at 8:40am revealed:
-He did not know about Resident #3 being locked out in the main common area until around 03/24/25 when the Administrator was investigating the incident.
-He trained staff to approach Resident #3 calmly, slowly, with a low tone and hold her hand for the best results.
-It was against their policy to lock Resident #3 in the main common area and against Resident #3's rights to restrict access to her room.
-After he found out about Resident #3 being locked out in the main common area, he spoke to all staff about intervention to help Resident #3 and that no one was to be left out in the common area unsupervised.

Interview with the HWD on 04/16/25 at 5:58pm revealed:
-He did not know Resident #3 was locked in the main common area on 03/19/25 or 03/20/25.
-The incident was against Resident #3's rights because Resident #3 was not able to access her room.

Interview with the Administrator on 04/11/25 at 10:15am revealed:
-On 03/20/25, she received an incident report that staff locked Resident #3 in the main common area.
-On 03/20/25, when Resident #3 was locked in the main common area and not allowed access to

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D 338	Continued From page 28 her room, that was a violation of their supervision policy because Resident #3 required 24/7 supervision and against Resident #3's resident rights because that was her home and had no way to access it. -She was not aware of the incident until 03/20/25 after an email from a concerned family member and then when she received the incident report. [Refer to Tag D0468, 10A NCAC 13F .1309 Special Care Unit Staff Orientation and Training (Type A1 Violation)]. _____ The facility failed to ensure residents were treated with respect, consideration, dignity, and full recognition and her individuality when Resident #3 was locked in the common area of the facility unsupervised when staff did not know how to manage her agitation on multiple occasions. This failure resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/11/25 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 16, 2025.	D 338		
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.	D 438		

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D 438	Continued From page 29 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report injuries of unknown origin to the Health Care Personnel Registry (HCPR) for 1 of 4 sampled residents related to a laceration to the head (#4). The findings are: Review of the facility Incident Reporting and Investigation Policy dated 05/20/22 revealed: -A critical incident was described as an incident that was serious in nature and may require the incident reported to the local Department of Health and Human Services. -A resident with an injury of unknown origin was a reportable incident and was to be reported immediately. Review of Resident #4's current FL2 dated 09/24/24 revealed: -Diagnoses included Alzheimer's disease, anxiety disorder and history of breast cancer. -She was continent of bowel and bladder and was ambulatory. -She was constantly disoriented. -Her level of care was a Special Care Unit (SCU). Review of Resident #4's care plan updated 04/02/25 revealed: -She was independent with ambulation but required assistance and direction in an emergency. -She needed assist/cueing with transfers, bathing, grooming, dressing and dining/eating. -She was at moderate or high risk for falls. Review of Resident #4's Accident/Incident (A/I) Report dated 03/13/25 revealed:	D 438		

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-At 6:10am, she was found seated on the sofa in the common area with blood and an abrasion located on her forehead.
-She was unable to give a description of the incident.
-The injury was of unknown origin.

Review of the Resident #4's emergency department (ED) provider notes dated 03/13/25 at 7:24am revealed:
-Resident #4 was brought in by emergency medical services (EMS) from the nursing facility due to a fall.
-The fall was not witnessed.
-She had a laceration on her forehead.
-Her ED diagnoses included fall at nursing home, laceration of scalp and closed head injury.
-She was discharged back to the facility 03/13/25 at 12:47pm.

Review of the facility's 24-hour report dated 04/16/25 revealed:
-On 03/13/25 at 6:10am, Resident #4 was found seated in the common area with blood and an abrasion on her forehead.
-The 24-hour report was faxed to HCPR on 04/16/25 at 3:49pm instead of within the mandated 24-hours from the incident.

Review of Resident #4's Accident/Incident Report dated 03/13/25 at 6:10am revealed:
-Resident #4 was found seated on the sofa in the common area, with blood and an abrasion located on her forehead.
-Staff called 911 and Resident #4 was transported to the hospital.
-Resident #4 was oriented to person and the initiation.

Review of Resident #4's 5-Day Health Care

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Personnel Registry (HCPR) report dated 04/16/25 revealed it was faxed to HCPR on 04/16/25 at 3:50pm.

Interview with the Administrator on 04/16/25 at 6:48pm revealed:
-Her expectation was that a 24-hour report was completed when there was an unwitnessed event that required medical intervention for possible injury.
-She was responsible for doing the 24-hour and the 5-day reports.
-The Health and Wellness Director (HWD) was responsible to complete the 24-hour reports in her absence.
-She thought she had completed a 24-hour/5-day HCPR report for Resident #4 related to her injury that was discovered on 03/31/25.

2. Review of Resident #3's current FL2 dated 10/08/24 revealed:
-Diagnoses included dementia, Alzheimer's disease, and hypertension.
-She was ambulatory.
-Her level of care was a Special Care Unit (SCU).

Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 11/18/20.

a. Review of Resident #3's 24-Hour Health Care Personnel Registry (HCPR) Initial Report dated 03/24/25 revealed:
-The incident happened on 03/19/25 at 8:00pm.
-On 03/21/25, the Administrator was notified via email that a resident was locked out of the hall that lead to her room to restrict her, in the common area of the facility by a staff member.
-The 24-hour report was faxed to HCPR on 03/24/25 at 5:30pm instead of within the

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D 438	Continued From page 32 mandated 24-hours from the incident. Review of Resident #3's 5-day HCPR report dated 03/26/25 revealed: -On 03/19/25, Resident #3 was restricted to the main common area and not allowed to return to her room by a MA leaving her unattended because she was agitating other residents in the SCU neighborhood. -The MA locked Resident #3 in the main common area without supervision instead of reaching out to the supervisor or other staff for assistance. -It "appeared" Resident #3 was locked in the main common area without supervision for about an hour before another staff member working in another hall heard Resident #3 knocking on that hallway's doors. -Resident #3's 5-Day Report was faxed to HCPR on 03/26/25 at 3:50pm instead of mandated 5 days from the incident. b. Review of Resident #3's 24-hour HCPR report dated 04/04/25 revealed: -On 04/04/25 at 1:44pm, Resident #3 was observed with a slightly swollen lower lip and a scratch on her face. -The 24-hour report faxed to HCPR on 04/06/25 at 1:56pm instead of within the mandated 24-hours from the incident. Review of Resident #3's 5-Day HCPR report dated 04/04/25 revealed: -On 04/04/25 at 1:44pm, Resident #3 was observed with a slightly swollen lower lip and a scratch on her face. -There was no accused individual. -It was faxed to HCPR on 04/16/25 at 3:50pm instead of the mandated 5 days from the incident. Interview with the Administrator on 04/16/25 at	D 438		

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D 438	Continued From page 33 6:48pm revealed: -Her expectation was that a 24-hour report would be completed when there was an unwitnessed event that required medical intervention for possible injury. -She was responsible for doing the 24-hour and the 5-day HCPR reports. -The HWD was responsible to complete the 24-hour reports in her absence. -She thought she had completed a 24-hour/5-day reports for Resident #3 related to her injury that was discovered on 04/04/25.	D 438		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the minimum number of staff were always present to meet the needs of residents residing in the special care unit (SCU) for 11 of 51 shifts sampled between January 2025 and April 2025. The findings are:	D 465		

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D 465	Continued From page 34 1. Review of facility census on 02/14/25 revealed there were 44 residents. Review of the assignment sheet and schedule for 02/14/25 revealed there were 4 staff scheduled to work on 3rd shift. Review of facility time punches for 3rd shift on 02/14/25 revealed: -Based on a census of 44 residents the facility required a minimum of 35.2 hours on 3rd shift and was 2.95 hours short. -There were 32.25 hours worked on 3rd shift. Refer to interview with a personal care aide (PCA) on 04/01/25 at 1:50pm. Refer to telephone interview with a second PCA on 04/15/25 at 11:23am. Refer to interview with a MA on 03/21/25 at 11:20am. Refer to interview with a second MA on 04/03/25 at 2:15pm. Refer to interview with the Health and Wellness Director (HWD) and the Assistant HWD on 04/01/25 at 12:35pm. Refer to interview with the Assistant HWD on 04/15/25 8:15am. Refer to telephone interview with the Administrator on 03/25/25 at 8:00pm. Refer to interview with the Administrator on 04/09/25 at 12:45pm. 2. Review of the facility census on 02/15/25	D 465		

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D 465	Continued From page 35 revealed there were 44 residents. Review of the assignment sheet and schedule for 02/15/25 revealed there were 4 staff scheduled to work on 3rd shift. Review of facility time punches for 3rd shift on 02/15/25 revealed: -Based on a census of 44 residents the facility required a minimum of 35.2 hours on 3rd shift and was 2.70 hours short. -There were 32.5 hours worked on 3rd shift. Refer to interview with a PCA on 04/01/25 at 1:50pm. Refer to telephone interview with a second PCA on 04/15/25 at 11:23am. Refer to interview with a MA on 03/21/25 at 11:20am. Refer to interview with a second MA on 04/03/25 at 2:15pm. Refer to interview with the Health and Wellness Director (HWD) and the Assistant HWD on 04/01/25 at 12:35pm. Refer to interview with the Assistant HWD on 04/15/25 8:15am. Refer to telephone interview with the Administrator on 03/25/25 at 8:00pm. Refer to interview with the Administrator on 04/09/25 at 12:45pm. 3. Review of the facility census on 02/24/25 revealed there were 45 residents.	D 465		

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D 465	Continued From page 36 Review of the assignment sheet and schedule for 02/24/25 revealed there were 4 staff scheduled to work on 3rd shift. Review of facility time punches for 3rd shift on 02/24/25 revealed: -Based on a census of 45 residents the facility required a minimum of 36 hours on 3rd shift and was 2.75 hours short. -There were a total of 32.25 hours worked on 3rd shift. Refer to interview with a PCA on 04/01/25 at 1:50pm. Refer to telephone interview with a second PCA on 04/15/25 at 11:23am. Refer to interview with a MA on 03/21/25 at 11:20am. Refer to interview with a second MA on 04/03/25 at 2:15pm. Refer to interview with the Health and Wellness Director (HWD) and the Assistant HWD on 04/01/25 at 12:35pm. Refer to an interview with the Assistant HWD on 04/15/25 8:15am. Refer to telephone interview with the Administrator on 03/25/25 at 8:00pm. Refer to interview with the Administrator on 04/09/25 at 12:45pm. 4. Review of the facility census on 02/25/25 revealed there were 45 residents.	D 465		

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D 465	Continued From page 37 Review of the assignment sheets and schedule for 02/25/25 revealed there were 4 staff scheduled to work on 3rd shift. Review of facility time punches for 3rd shift on 02/25/25 revealed: -Based on a census of 45 residents the facility required a minimum of 36 hours on 3rd shift and was 3.5 hours short. -There were 32.5 hours worked on 3rd shift. Refer to interview with a PCA on 04/01/25 at 1:50pm. Refer to telephone interview with a second PCA on 04/15/25 at 11:23am. Refer to interview with a MA on 03/21/25 at 11:20am. Refer to interview with a second MA on 04/03/25 at 2:15pm. Refer to interview with the Health and Wellness Director (HWD) and the Assistant HWD on 04/01/25 at 12:35pm. Refer to interview with the Assistant HWD on 04/15/25 8:15am. Refer to telephone interview with the Administrator on 03/25/25 at 8:00pm. Refer to interview with the Administrator on 04/09/25 at 12:45pm. 6. Review of the facility census on 02/27/25 revealed there were 45 residents.	D 465		

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D 465	Continued From page 38 Review of the assignment sheet and schedule for 02/27/25 revealed there were 4 staff scheduled to work on 3rd shift. Review of facility punches for 3rd shift on 02/27/25 revealed: -Based on a census of 45 the facility required a minimum of 36 hours on 3rd shift and was 3.5 hours short. -There were a total of 32.5 hours worked on 3rd shift. Refer to interview with a PCA on 04/01/25 at 1:50pm. Refer to telephone interview with a second PCA on 04/15/25 at 11:23am. Refer to interview with a MA on 03/21/25 at 11:20am. Refer to interview with a second MA on 04/03/25 at 2:15pm. Refer to interview with Health and Wellness Director (HWD) and the Assistant HWD on 04/01/25 at 12:35pm. Refer to interview with the Assistant HWD on 04/15/25 8:15am. Refer to telephone interview with the Administrator on 03/25/25 at 8:00pm. Refer to interview with the Administrator on 04/09/25 at 12:45pm. 7. Review of facility census on 02/28/25 revealed there were 45 residents.	D 465		

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D 465	Continued From page 39 Review of assignment sheets and schedule for 02/28/25 revealed there were 4 staff scheduled to work on 3rd shift. Review of facility time punches for 3rd shift on 02/28/25 revealed: -Based on a census of 45 residents, the facility required a minimum of 36 hours on 3rd shift and was 4 hours short. -There were a total of 32 hours worked on 3rd shift. Refer to interview with a PCA on 04/01/25 at 1:50pm. Refer to telephone interview with a second PCA on 04/15/25 at 11:23am. Refer to interview with a MA on 03/21/25 at 11:20am. Refer to interview with a second MA on 04/03/25 at 2:15pm. Refer to interview with the Health and Wellness Director (HWD) and the Assistant HWD on 04/01/25 at 12:35pm. Refer to interview with the Assistant HWD on 04/15/25 8:15am. Refer to telephone interview with the Administrator on 03/25/25 at 8:00pm. Refer to interview with the Administrator on 04/09/25 at 12:45pm. 8. Review of the facility census on 03/01/25 revealed there were 45 residents.	D 465		

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D 465	Continued From page 40 Review of assignment sheets and schedule for 03/01/25 revealed there were 5 staff scheduled to work 3rd shift. Review of facility time punches for 3rd shift on 03/01/25 revealed: -Based on a census of 45 the facility required a minimum of 36 hours on 3rd shift and was 2.75 hours short. -There were a total of 33.25 hours worked on 3rd shift. Refer to interview with a PCA on 04/01/25 at 1:50pm. Refer to telephone interview with a second PCA on 04/15/25 at 11:23am. Refer to interview with a MA on 03/21/25 at 11:20am. Refer to interview with a second MA on 04/03/25 at 2:15pm. Refer to interview with the Health and Wellness Director (HWD) and the Assistant HWD on 04/01/25 at 12:35pm. Refer to interview with the Assistant HWD on 04/15/25 8:15am. Refer to telephone interview with the Administrator on 03/25/25 at 8:00pm. Refer to interview with the Administrator on 04/09/25 at 12:45pm. 9. Review of facility census on 03/19/25 revealed there were 44 residents.	D 465		

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D 465	Continued From page 41 Review of assignment sheets and schedule for 03/19/25 revealed there were 4 staff scheduled to work on 3rd shift. Review of facility time punches for 3rd shift on 03/19/25 revealed: -Based on a census of 44, the facility required a minimum of 35.2 hours on 3rd shift and was 2.45 hours short. -There were a total of 32.75 hours worked on 3rd shift. Refer to interview with a PCA on 04/01/25 at 1:50pm. Refer to telephone interview with a second PCA on 04/15/25 at 11:23am. Refer to interview with a MA on 03/21/25 at 11:20am. Refer to interview with a second MA on 04/03/25 at 2:15pm. Refer to interview with the Health and Wellness Director (HWD) and the Assistant HWD on 04/01/25 at 12:35pm. Refer to interview with the Assistant HWD on 04/15/25 8:15am. Refer to telephone interview with the Administrator on 03/25/25 at 8:00pm. Refer to interview with the Administrator on 04/09/25 at 12:45pm. 10. Review of facility census on 03/20/25 revealed there were 44 residents.	D 465		

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D 465	Continued From page 42 Review of assignment sheets and schedule for 03/20/25 revealed there were 4 staff scheduled to work on 3rd shift. Review of facility time punches for 3rd shift on 03/20/25 revealed: -Based on a census of 44 the facility required a minimum of 35.2 hours on 3rd shift and was 3.2 hours short. -There were a total of 32 hours worked on 3rd shift. Refer to interview with a PCA on 04/01/25 at 1:50pm. Refer to telephone interview with a second PCA on 04/15/25 at 11:23am. Refer to interview with a MA on 03/21/25 at 11:20am. Refer to interview with a second MA on 04/03/25 at 2:15pm. Refer to interview with the Health and Wellness Director (HWD) and the Assistant HWD on 04/01/25 at 12:35pm. Refer to interview with the Assistant HWD on 04/15/25 8:15am. Refer to telephone interview with the Administrator on 03/25/25 at 8:00pm. Refer to interview with the Administrator on 04/09/25 at 12:45pm. 11. Review of facility census on 04/07/25 revealed a census of 49 residents.	D 465		

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Review of assignment sheets and schedule for 04/07/25 revealed there were 6 staff scheduled to work on 2nd shift.

Review of facility time punches for 2nd shift on 04/07/25 revealed:
-Based on a census of 49 residents, the facility required a minimum of 49 hours on 2nd shift and was 2 hours short.
-There were a total of 47 hours worked on 2nd shift.

Review of Resident #10's current FL2 dated 02/11/25 revealed:
-Diagnoses included moderate dementia with anxiety.
-She was intermittently disoriented.
-She was ambulatory.
-She was continent of bowel and bladder.
-Her level of care was SCU.

Review of Resident #10's Care Plan updated 04/09/25 revealed:
-She was independent with ambulation but required assistance to vacate the building in an emergency.
-She required stand-by supervision with dressing.
-She was at moderate or high risk for falls based on her fall assessment.
-Her caregivers were to remind her to use call device for assistance and would become familiar with her daily routine and try to anticipate her needs daily.
-She would be provided with a safe environment that was clutter free with personal items within reach.
-She required moderate supervision needs in the home and needed attendance when outside the home.
-Her caregivers were to remind her to wear

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glasses when awake and assist with eye care as needed.

Review of Resident #10's Accident/Incident (A/I) Report dated 04/07/25 revealed:
-At 3:20pm she was observed on the floor in front of her apartment.
-She stated she fell back and struck her head on the floor.
-No injuries were observed at time of incident.
-She was ambulatory without assistance.
-She was transported by Emergency Management Services (EMS) to the Emergency Room (ER).

Review of Resident #9's current FL-2 dated 01/14/25 revealed:
-Diagnosis included mild dementia, cognitive impairment, chronic atrial fibrillation, chronic kidney disease, macular degeneration and osteopenia.
-She was admitted to the facility on 01/07/2025.
-She was ambulatory.
-She was intermittently disoriented.

Review of Resident #9's care plan initiated on 02/18/25 revealed:
-She was a fall risk.
-She was able to ambulate using cane or walker without assistance.
-She was independent with toileting and needed verbal cues/reminders for dressing.

Review of Resident's #9's Accident/Incident (A/I) report dated 04/07/25 revealed:
-At 3:30pm, she had an unwitnessed fall.
-Staff heard a loud noise and Resident #9 was crying out for help.
-She was oriented to person and situation and able to say she had fallen.

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D 465	Continued From page 45 -There was water on the floor. Refer to interview with a PCA on 04/01/25 at 1:50pm. Refer to telephone interview with a second PCA on 04/15/25 at 11:23am. Refer to interview with a MA on 03/21/25 at 11:20am. Refer to interview with a second MA on 04/03/25 at 2:15pm. Refer to interview with the Health and Wellness Director (HWD) and the Assistant HWD on 04/01/25 at 12:35pm. Refer to interview with the Assistant HWD on 04/15/25 8:15am. Refer to a telephone interview with the Administrator on 03/25/25 at 8:00pm. Refer to interview with the Administrator on 04/09/25 at 12:45pm. 12. Review of facility census on 04/07/25 revealed a census of 49 residents. Review of assignment sheets and schedule for 04/07/25 revealed there were 4 staff scheduled to work on 3rd shift. Review of facility time punches for 3rd shift on 04/07/25 revealed: -Based on a census of 49 residents the facility required a minimum of 49 hours on 3rd shift and was 5.6 hours short. -There were a total of 32 hours worked on 3rd	D 465		

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D 465	Continued From page 46 shift. Observation on 04/11/25 at 6:07am revealed on 3rd shift, there was one staff member assigned to each of the three hallways and a MA who floated between the three hallways. Refer to interview with a PCA on 04/01/25 at 1:50pm. Refer to telephone interview with a second a second PCA on 04/15/25 at 11:23am. Refer to interview with a MA on 03/21/25 at 11:20am. Refer to interview with a second MA on 04/03/25 at 2:15pm. Refer to interview with the Health and Wellness Director (HWD) and the Assistant HWD on 04/01/25 at 12:35pm. Refer to interview with the Assistant HWD on 04/15/25 8:15am. Refer to telephone interview with the Administrator on 03/25/25 at 8:00pm. Refer to interview with the Administrator on 04/09/25 at 12:45pm. _____ Interview with a PCA on 04/01/25 at 1:50pm revealed: -The hallway where they worked never had more than 2 staff assigned on first and second shift. -There were several residents that required at least 2 staff when providing personal care. -When the two staff were providing care to a	D 465		

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resident, there was no other staff member that could supervise the other residents and respond quickly when needed.
-When she was hired, she was told there would be 2 PCAs and a MA in each of the three hallways in the facility.
-When she first started working in the facility, there were 3 staff in the hallways on 1st and 2nd shift, but when that Administrator left, the staffing decreased to only 2 staff members in the hallway.

Telephone interview with a second PCA on 04/15/25 at 11:23am revealed:
-When she first started working at the facility, there were 2 PCAs and one MA scheduled to work in each hallway.
-After the Administrator that hired her left, staffing was decreased but the census has continued to increase to a point that proper supervision had become unmanageable in the facility.
-She and other staff had advocated that 2 staff in each hallway was not sufficient to properly supervise the residents, but no changes had been made to staffing levels.
-When there was only a MA and a PCA scheduled to work in a hallway and the MA was in the middle of passing medications and the PCA was in a resident's room assisting with personal care, there was no staff available to supervise all the other residents.
-She had never observed another staff member from another hallway come to the hallway to provide coverage while the MA was passing medications in other hallways.
-When she was left alone in the hallway, she just had to "do the best she could" by herself because she could not leave the hallway to go ask for help and staff did not all have each other's phone numbers to call to ask for help.
-The current staffing level in the hallways was not

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good for the residents or the staff.
-There had been several falls due to insufficient staffing to provide proper supervision.

Interview with a MA on 03/21/25 at 11:20am revealed:
-She usually worked as a MA floating between two hallways.
-Today, she was working as a PCA in a hallway of the facility that typically had one assigned PCA and a floating MA.
-The floating MA was supposed to spend most of her time in this hallway, because the other hallway she floated between already had 2 PCAs assigned to it.
-She had not seen the MA that was supposed to be working in this hallway with her yet today.
-It was challenging to supervise all 16 residents when there was only one staff in the hallway.
-When she was in a resident's room providing incontinence care to a resident, she was unable to supervise the other 15 residents.

Interview with a second MA on 04/03/25 at 2:15pm revealed:
-There were at least 3 residents in the hallway that staff all knew required 2-person assistance because of their behaviors.
-When both staff that were assigned to the hallway were assisting these 3 residents, there was no staff left to supervise the other residents.
-When she first started working on the hallway, there were always 3 staff assigned to the hallway but now there were only 2 scheduled.
-She tried to express concern about the staffing levels in the hallways multiple times during the month of March 2025, but the HWD and the Administrator were unresponsive.
-Every other Wednesday, the PCA that usually worked with her was off, and no other staff was

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scheduled to come in to work on the hallways at 7:00am when she came in.
-No one else was scheduled to come in at 7:00am on those days, she was alone on the hallways for 1.5 hours until someone else came in at 8:30am.
-Due to the lack of staff, she had to get up all the residents on the hallway and assist them with toileting, get them all to the table for breakfast, serve the meal and assist with feeding if necessary.

Interviews with the Health and Wellness Director (HWD) and the Assistant HWD on 04/01/25 at 12:35pm revealed:
-The Assistant HWD was responsible for managing the staffing schedule.
-It was the Assistant HWD's understanding that they were currently staffing 1 staff to 8 residents on 1st and 2nd shift, and 1 to 10 residents on 3rd shift.
-He had been staffing 4 staff on third shift; one PCA in each of the three hallways and a MA who floated between the hallways as needed.
-He thought 4 staff on third shift was sufficient.

Interview with the Assistant HWD on 04/15/25 8:15am revealed:
-There were usually 3-4 staff members in the facility during 3rd shift.
-3rd shift was also responsible for washing and drying laundry and checking on residents throughout the shift as they return residents' laundry.
-Since there was one PCA assigned to each hallway on 3rd shift and a MA that floated between the hallways, the PCA in the hallway would call the MA to provide coverage to their hallway while they were in the laundry room.

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D 465	Continued From page 50 Telephone interview with the Administrator on 03/25/25 at 8:00pm revealed the facility should have been adequately staffed because they staffed to the residents needs based on their service plans, rather than the state minimum requirements. Interview with the Administrator on 04/09/25 at 12:45pm revealed: -She was not aware that facility was not staffed to the requirements on all shifts. -Her expectation was that the HWD and Assistant HWD would ensure the facility was meeting the minimum staffing requirements on all shifts. -She would research the days that were short to find out if there were additional staff that may have worked on those days. -The staff did not make her aware of short staffed shifts. [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]. [Refer to Tag D0338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. _____ The facility failed to ensure there was staff to meet the required staffing hours and the needs of 44-49 residents with cognitive deficits whose level of care was SCU for 11 of 51 shifts sampled resulting in the supervision of residents not being met or being delayed. On 04/07/25, on second shift the facility was short staffed when Resident #9 fell and was sent out to the Emergency Department and diagnosed with a contusion of her right hip, and Resident #10 who fell and was sent out to the ED and diagnosed with a hematoma to the back of her head. This failure	D 465		

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D 465	Continued From page 51 resulted in a serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/11/25 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 16, 2025.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in	D 468		

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Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews and record reviews, the facility failed to ensure all staff completed 6-hours of Special Care Unit (SCU) specific training within a week of hire and an additional 20-hours of SCU specific training within 6-months of hire, including 4 of 5 staff (Staff A, Staff B, Staff C, and Staff D).

The findings are:

Review of Resident #7's current FL-2 dated 03/11/25 revealed:
-Diagnoses included Alzheimer's/dementia.
-He was constantly disoriented and ambulatory.
-His level of care was SCU.

Review of Resident #7's Resident Register revealed he was admitted to the facility on 03/03/25.

Observation on 04/15/25 at 11:35am of Resident #7 revealed:
-He was walking through the main area of the facility looking at the outdoors.
-He paced around the halls and walked at a faster pace.

Review of Resident #7's accident/incident (A/I) report dated 03/04/25 at 6:00pm revealed:
-The report was completed by the second shift

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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
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medication aide (MA).
-Resident #7 was very agitated; he was going into other resident rooms and opening all the doors.
-He had "unmanageable manic" behavior.
-He was confused and had impaired memory but oriented to person.
-Staff called the responsible party and emergency medical services (EMS).
-Resident #7's physiological risks factors include confusion, impaired memory.
-Resident #7's situational risk factors included he had active exit seeking behaviors and was admitted within the last 72 hours.

Telephone interview with Resident #7's Responsible Party on 04/16/25 at 9:32am revealed:
-Resident #7 had temporal lobe dementia (an umbrella term used to describe a group of brain diseases that mainly affect the areas of the brain associated with personality, behavior and language).
-Resident #7 was not familiar with his new surroundings and was "out of his element, and this was not normal behavior for him".

Review of Resident #7's EMS report dated 03/04/25 revealed:
-A unit was dispatched on 03/04/25 at 8:46pm for a resident and arrived at the facility 9:20pm.
-Resident #7 was standing in the doorway of his bedroom.
-He did not present with any combative behavior throughout contact and was "very welcoming."
-He was oriented to person but not oriented to time, place or situation.
-Facility staff reported Resident #7 had been combative and would like the resident to receive an evaluation.
-He was transported to the Emergency

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D 468	Continued From page 54 Department (ED) for an evaluation at 9:51pm. Review of Resident #7's ED provider notes dated 03/05/25 revealed: -Resident #7 presented to the ED for increased agitation with staff. -Resident #7 was unable to give any history due to severe dementia. -Resident #7 was calm, pleasant and cooperative speaking kindly to staff, smiling. -Resident #7 exhibited no aggressive behavior or evidence of agitation. -Resident #7 did not appear to have an acute psychiatric disorder. -Resident #7 was calm, comfortable and pleasant. -Resident #7 was discharged back to the facility at 11:21am on 03/05/25. Telephone Interview with a PCA on 04/16/25 at 3:30pm revealed: -She was working second shift (3:00pm to 11:00pm) on 03/04/25 on the hallway where Resident #7 resided when Resident #7 experienced his behavior episode on 03/04/25. - She was informed by first shift staff that Resident #7 had not slept since the night before on 03/03/25. -Resident #7 was going into other resident rooms and was unaware of where he was and it was very difficult to calm him down. -He was a new admission and the staff did not know a lot about him. -She was not aware of what to do for Resident #7. -EMS came to the facility and took the resident to the hospital. Telephone interview with Resident #7's PCP on 04/16/25 at 11:47am revealed:	D 468		

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-Resident #7 was newly admitted to the facility on 03/03/25 and was still getting accustomed to his new environment.
-He was made aware of Resident #7's behaviors on 03/04/25.
-The staff had to ensure the safety of other residents but expected Resident #7 to be supervised when exhibiting the type of behaviors he had on 03/04/25
.
Telephone interview with Resident #7's Psychiatrist on 04/16/25 at 3:41pm revealed:
-Resident #7 was last seen for an initial visit on 03/06/25.
-Resident #7 required 24/7 supervision and that was why Resident #7 was admitted to the SCU.

Review of staff personnel files and staff interviews revealed the following:

1. Review of Staff A's personnel file revealed:
-Staff A was hired on 11/25/23 as a personal care aide (PCA).
-There was documentation that Staff A completed the required 6-hours of SCU specific training within the first week of hire.
-There was documentation that Staff A completed an additional 3.25 hours of SCU specific training within 6-months of hire but did not meet the requirement of 20 additional hours within the first 6-months of hire.

Telephone interview with Staff A on 04/16/25 at 5:10pm revealed
-He had been employed with the facility for over a year.
-He completed the 6-hours of SCU training during the first week.
-He did not complete the additional 20-hours of SCU specific training during the first 6 months,

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stating he "only had a few trainings left".
-Staff had access to the SCU specific online training modules so they could complete them at their own pace
-When he first started working at the facility, he shadowed other staff to learn how to care for the residents.

Refer to interview with the Assistant Health and Wellness Director (HWD) on 04/16/25 at 5:20pm.

Refer to interview with the HWD on 04/16/25 at 5:50pm.

Refer to interview with the Administrator on 04/16/25 at 6:25pm.

2. Review of Staff B's employee file revealed:
-Staff B was hired on 04/08/24 as a PCA.
-There was no documentation in Staff B's file of completion of any SCU specific training, including 6-hours within the first week or 20 additional hours within the first 6 months.

Telephone interview with Staff B on 04/16/25 at 3:38pm revealed:
-She had been employed with the facility for about a year and had no experience working in facilities prior to being hired.
-Upon hire, she received no online training for "at least a few months".
-Initially, all her training occurred while she was working in the facility shadowing other staff.
-When she first started working for the company, the Assistant HWD told her she would work mostly at the assisted living sister facility next door because she "had no experience working with residents with dementia" and would slowly be scheduled more to work in the SCU facility as she gained experience after at least 6 weeks in the

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sister facility, but this is not what happened.
-She worked in the assisted living sister facility for 2 or 3 days, and then worked one day in each of the three hallways at the SCU facility before she was scheduled to work on her own in the facility.
-The hallway she was always assigned to was known as the "most challenging" hallway for behaviors and falls.
-She did not complete 6-hours of SCU training within the first week of hire or 20-hours within the first 6 months.
-Management did not tell her she needed to complete any SCU training and no management ever followed-up with her to see if she had completed the trainings.
-Several MAs she worked with told her she should complete the online trainings because they would be helpful to her in learning how to deal with the residents, especially those with behaviors.
-There were a few MAs who primarily trained her and taught her how to interact with the residents and the right approach to use for different residents.
-She recalled the most helpful advice she received was to "try to sit down and talk to them and get to know them".
-She was terminated for locking a resident in the common area outside of the hallways because the resident was agitating other residents, and there was no other staff to help her supervise all the residents on the hallway.
-The common area had been used for residents with behaviors by other staff on many occasions in the past and no one had ever taught her that this was an inappropriate intervention.
-The Assistant Health and Wellness Director (HWD) was aware the common area had been used in this way and had never told her or any other staff that this was not acceptable.

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D 468	Continued From page 58 Review of Resident #3's current FL2 dated 10/08/24 revealed: -Diagnoses included dementia Alzheimer disease, and hypertension. -She was ambulatory. -She was incontinent of bowel and bladder. -Her level of care was a Special Care Unit (SCU). Review of Resident #3's Care Plan dated 02/12/25 revealed: -She required supervision with ambulation. -She required limited assistance with eating and transfers. -She was totally dependent with toileting, bathing, dressing and grooming. Review of a 24-Hour Health Care Personnel Registry (HCPR) investigation Initial Report dated 03/24/25 revealed: -On 03/21/25, the Administrator was notified via email that Resident #3 was locked out of the hall that lead to her room to restrict her in the main common area of the facility, without access to her personal belongings, by a staff member. -The incident date was 03/19/25 at 8:00pm. -The initial discussion with a MA revealed Resident #3 was restricted to the main common area and checked on frequently by staff Review of a 5-day HCPR investigation report dated 03/24/25 revealed: -Resident #3 was restricted to the main common area and not allowed to return to her room by a MA leaving her unattended because she was agitating other residents. -The MA locked Resident #3 in the main common area (still behind locked doors) without supervision instead of reaching out to the supervisor or other staff for assistance.	D 468		

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D 468	Continued From page 59 -It appeared Resident #3 was locked in the common area without supervision for about an hour before another staff member working in another hall heard Resident #3 knocking on Resident #3's hallway doors. -The facility was fully staffed and there were other staff to call on the walkie talkie for assistance per the protocol. -The MA told another resident's family member why she locked Resident #3 in the main common area violating Resident #3's confidentiality. Interview with the Administrator on 04/01/25 at 3:45am revealed: -She looked into the circumstance regarding Resident #3 being locked in the main common area recently and determined she did not initially have all the information about the situation. -She was not aware that the doors to the other hallways leading to the other resident's rooms were locked and there were no staff in the main common area in which Resident #3 was placed. -Resident #3's behaviors had continued to increase and there was an altercation again on 03/31/25 when Resident #3 pushed another resident. -She met with Resident #3's Responsible Party (RP) yesterday to discuss increasing her level of care, as well as to discuss the situation in which she was locked in the main common area. Interview with the Administrator on 04/11/25 at 10:15am revealed: -On 03/20/25, she received an incident report that staff locked Resident #3 in the main common area. -On 03/20/25, when Resident #3 was locked in the main common area and not allowed access to her room, that was a violation of their supervision policy because Resident #3 required 24/7	D 468		

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supervision and against Resident #3's resident rights because that was her home and had no way to access it.
-She was not aware of the incident until 03/20/25 after an email from a concerned family member and then when she received the incident report.

Refer to interview with the Assistant HWD on 04/16/25 at 5:20pm.

Refer to interview with the HWD on 04/16/25 at 5:50pm.

Refer to interview with the Administrator on 04/16/25 at 6:25pm.

3. Review of Staff C's employee file revealed:
-Staff C was hired on 04/13/21 as a Medication Aide (MA).
-There was no documentation that Staff C completed the required 6-hours of SCU specific training within the first week of hire.
-There was documentation that Staff C completed an additional 14.42 hours of SCU specific training within 6-months but did not meet the requirement of 20 additional hours within the first 6 months.

Telephone interview with Staff C on 04/16/25 at 4:53pm revealed:
-She recalled completing some trainings online when she was hired, but she was not sure if she had completed 6-hours in the first week or 20-hours within the first 6 months.
-Most of her training occurred while she was shadowing other staff, who taught her how to take care of the residents, how to redirect them, and how to provide personal care to them.

Refer to interview with the Assistant HWD on 04/16/25 at 5:20pm.

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D 468	Continued From page 61 Refer to interview with the HWD on 04/16/25 at 5:50pm. Refer to interview with the Administrator on 04/16/25 at 6:25pm. 4. Review of Staff D's employee file revealed: -Staff D was hired 04/08/24 as a MA. -There was no documentation that Staff D completed the required 6-hours of SCU specific training within the first week of hire. -There was documentation that Staff D completed the required additional 20 hours of SCU specific training within the first 6 months. Telephone interview with Staff D on 04/16/25 at 4:30pm revealed: -She recalled she did not complete the 6-hours of SCU training within the first week of hire. -She completed the 6-hours of SCU training but it was "a few months late". -No management followed up with her to ensure she had completed the training. -She recalled completing the additional 20-hours of SCU training within 6 months of hire. -Most of her training at the facility occurred while she was shadowing other staff and working in the facility. Refer to interview with the Assistant HWD on 04/16/25 at 5:20pm. Refer to interview with the HWD on 04/16/25 at 5:50pm. Refer to interview with the Administrator on 04/16/25 at 6:25pm. _____	D 468		

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D 468	Continued From page 62 Interview with the Assistant HWD on 04/16/25 at 5:20pm revealed: -It was his understanding that the Business Office Manager (BOM) was responsible for ensuring all staff training was completed timely. -The Health and Wellness Director (HWD) was responsible for coordinating with the BOM to ensure all staff completed the required trainings timely. -He did not have access to the online training system to see any training documentation to know which staff had completed the special care unit training. -When new staff were hired, they were scheduled to shadow "seasoned" staff until their Licensed Health Professional Support (LHPS) validation was completed. Interview with the HWD on 04/16/25 at 5:50pm revealed: -He thought the first 6-hours of SCU specific training was completed during day 2 of orientation. -He was not aware of any process in which he and the Assistant HWD would know which staff had completed the 6-hour and 20-hour SCU trainings, or when the trainings were due. -The BOM was responsible for ensuring trainings were completed timely. Interview with the Administrator on 04/16/25 at 6:25pm revealed: -Online training was scheduled for the second day of orientation to complete the 6-hours of SCU training that was required within the first week of hire. -She was unsure why staff were not completing the training during the second day of orientation. -The BOM was responsible for ensuring all staff training was completed timely.	D 468		

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D 468	Continued From page 63 -The BOM was out of the country. -She was responsible for auditing the BOM's employee files to ensure compliance. [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]. [Refer to Tag D0338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. _____ The facility failed to ensure all staff completed the required 6-hour SCU specific training within the first week of hire and the additional 20-hour SCU specific training within six months of hire for 4 of 5 sampled staff, resulting in staff not being to care for residents with Alzheimer's/dementia who resided in the SCU. Staff failed to have an understanding of the nature and needs of Resident #3 and #7, who both were diagnosed with Alzheimer's/dementia and exhibited behaviors associated with dementia including frequent, fast walking, entering other resident's rooms and areas in the SCU and pushing others away who touched them. After displaying behavior associated with dementia during his second day in the SCU, Resident #7 was sent to the emegency room when staff did not know what to do. Resident #3 was confined to the common area of the facility alone when staff could not superivse the resident. The failure to ensure staff were properly trained with an understanding of the nature and needs of residents with Alzheimer's/dementia resulted in serious neglect of Resident #3 and Resident #7 and constitutes an A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/25 for	D 468		

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D 468	Continued From page 64 this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 16, 2025.	D 468		