

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060162	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/07/2025
NAME OF PROVIDER OR SUPPLIER THE HAVEN IN HIGHLAND CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 5920 MCCHESENEY DRIVE CHARLOTTE, NC 28269		
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up survey and compliant investigation on June 30, 2025 through July 3, 2025 and July 7, 2025. The compliant investigation was initiated by Mecklenburg County Department of Social Services on May 28, 2025.	D 000		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information;	D 253		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 253	Continued From page 1 (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10) skin integrity; (11) memory, orientation and cognition; (12) vision and hearing; (13) speech and communication; (14) assistive devices needed; and (15) a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicare/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost.	D 253		

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D 253	Continued From page 2 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 9 sampled residents (#7) had a care plan completed within 30 days of admission. The findings are: Review of Resident #7's current FL2 dated 05/20/25 revealed: -Diagnoses include dementia and vitamin D deficiency. -He was constantly disoriented. -He was ambulatory. -His recommended level of care was Special Care Unit (SCU). Review of Resident #7's Resident Register revealed an admission date of 11/13/24. Review of Resident #7's record on 06/30/25 revealed there was no care plan available for review. Interview with the Care Services Assistant on 07/07/25 at 1:43pm revealed: -He did not know prior to 07/01/25 that Resident #7's care plan had not been completed. -The Administrator was responsible for completing resident care plans. -When asked how staff knew the needs of the residents on the SCU, he stated binders were placed for staff to review addressing the residents' needs. Interview with the Administrator on 07/07/25 at 2:22pm revealed:	D 253		

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D 253	Continued From page 3 -He, the Care Services Assistant prior to April 2025, and assistant Resident Care Director (RCD) were responsible for ensuring care plans were completed upon admission and every six months thereafter per facility policy. -He was not aware Resident #7's care plan was not completed within 30 days of admission. -When residents were admitted to the facility, he placed them on a tracker to ensure documents were completed on time. -He was unsure why Resident #7's care plan had not been completed within 30 days of admission	D 253		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up with a physician for 3 of 9 sampled residents (#2, #6, & #9) related to a urine that was collected without an order on two occasions (#6) orders for a sling to treat a fracture left arm (#9), and laboratory testing to monitor average blood sugar levels over the past 3 months and to measure the amount of lipids (fats) in the blood (#2). The findings are: 1. Review of Resident #9's current FL2 dated 01/14/25 revealed: -Diagnoses included dementia with behaviors, a	D 273		

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D 273	Continued From page 4 history of stroke and seizure disorder. -She was ambulatory. -She was constantly disoriented. -She was continent of bowel and bladder. -Her level of care was a Special Care Unit (SCU). Review of Resident #9's June 2025 progress notes revealed: -On 06/02/25 at 10:41am, a MA documented Resident #9 slammed her breakfast plate on the dining room table this morning and refused to eat. -On 06/02/25 at 12:02pm, a MA documented Resident #9 approached staff aggressively and threatened to punch and step on staff during meal time. -On 06/02/25 at 1:53pm, a MA documented Resident #9 walked up to another resident, swinging her arms at the other resident's face. -On 06/03/25 at 12:47pm, a MA documented Resident #9 was observed talking with another resident in an aggressive tone on two occasions. -The MA encouraged Resident #9 to leave the activity room. -When Resident #9 exited the activity room, she hit another resident on the left arm with her cane. -On 06/03/25 at 4:00pm, the Administrator documented Resident #9's PCP was starting an antibiotic for a urinary tract infection (UTI) before Resident #9 returned to the facility from home. -On 06/09/25 at 8:43pm, Resident #9 returned to the facility and continued to be on antibiotics. -On 06/24/25 at 10:56am, a MA documented Resident #9 was raising her cane at staff, other residents and outside agency staff while threatening to hit them with it. -On 06/24/25 at 1:15pm, the Care Services Assistant collected a urine sample due to increased behaviors. Review of Resident #9's July 2025 progress	D 273		

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D 273	Continued From page 5 notes revealed: -On 07/01/25 at 11:24am, a MA documented a urine sample was collected. -On 07/01/25 at 1:46pm, a MA documented Resident #9 lifted her cane towards another resident's face and her cane was taken away by physical therapy. -On 07/02/25 at 2:06pm, the Care Services Assistant documented physical therapy discontinued Resident #9's walker and cane. -On 07/02/25 at 10:52, a MA documented Resident #9 was provoking staff during meal time by raising her fist to everybody, redirection was not effective. -While staff were assisting another resident, Resident #9 became aggravated and chased the MA with a butter knife. -The Administrator stopped Resident #9 and she was sent out to the hospital. Interview with a MA on 07/07/25 at 11:25am revealed: -On 07/01/25 at 11:24am, she checked the refrigerator and saw a urine sample with Resident #9's name on it and a collection date of 06/24/25 still in the refrigerator. -She reported the urine sample dated 06/24/25 to the Care Services Assistant and he instructed her to dispose of that urine sample, collect another one. -She collected another urine sample from Resident #9 and handed the urine sample to the laboratory technician that was in the building on 07/01/25. -The Clinical Services Assistant told her he had received a telephone order for the urine sample dated 06/24/25 and there was a mix up and to get another sample and send it to the lab for processing.	D 273		

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D 273	Continued From page 6 Review of Resident #9's Record revealed there were no laboratory testing results for urine collected on 06/24/25 or 07/01/25. Interview with the Care Services Assistant on 07/07/25 at 12:00pm revealed: -On 06/24/25, Resident #9 hit another resident with her cane so he obtained a urine sample from Resident #9. -Resident #9 had just had a UTI a week or two before and thought that might be the issue now. -He did not call Resident #9's Primary Care Physician (PCP) because he used a standing order for the urine sample. -There was not an order in the system until 07/01/25 to collect a urine sample for Resident #9 and he was not sure why. -On 07/01/25, Resident #9 was threatening to use her cane to hit other residents. -Resident #9's physical therapy assistant observed the incident and removed the cane from Resident #9 and discontinued the cane due to Resident #9 not needing the cane for ambulation. Telephone interview with a representative from the facility's contracted laboratory on 07/03/25 at 1:00pm revealed: -On 06/24/25, the Care Services Assistant called for a pick up and was told there was no order in the system. -The 06/24/25 urine sample was not picked up at the facility because it was put on hold until an order was received. -On 06/24/25, a call was made to the Care Services Assistant and made him aware that there was no information as to the ordering physician was and that information was required to have the sample picked up. -On 07/01/25, a laboratory technician was at the facility and was given a "manual request form" to	D 273			

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D 273	Continued From page 7 collect Resident #9's urine sample. -The ordering provider's name was not the provider on the "manual request form" but a MA's name which the lab did not know at the time until the results were completed and a physician's name was not added to the lab results. -There was no order for the 07/01/25 urine sample. Telephone interview with Resident #9's PCP on 07/07/25 at 9:30am revealed: -Resident #9 had aggressive behaviors and was seeing a Mental Health Provider (MHP). -On 06/02/25, Resident #9's family member called him because Resident #9 was threatening to hurt another resident and the family member had taken Resident #9 home with her. -Resident #9's family member thought Resident #9 might have a urinary tract infection and requested an antibiotic due to painful urination. -He agreed and called in a prescription for an antibiotic for the family member to pick up. -Resident #9's family stated that Resident #9 would start the antibiotic and spend a few more days with her before going back to the facility. -On 06/02/25 after speaking with Resident #9's family member, he called the Administrator and informed him of what was going on with Resident #9. -He did not know about the Resident #9's aggressive behaviors or the need for a urine sample on 06/24/25 or 07/01/25. -He was at the facility on 07/01/25 and was not made aware of the need for a urine sample or the need for an order. -Increased agitation and confusion could be signs of a urinary tract infection. Interview with the Administrator on 07/07/25 at 11:18am revealed:	D 273		

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D 273	Continued From page 8 -Resident #9's aggressive behaviors increased in June 2025 and used her cane to hurt other residents. -A few days later he spoke to Resident #9's PCP about an antibiotic was ordered for Resident #9 and Resident #9 would return to the facility after a few days. -An increase in agitation could be a sign of a urinary tract infection in the elderly. -The Clinical Services Assistant informed him about collecting a urine sample for Resident #9 on 06/24/25 due to increased aggressive behaviors. -He was told by the Care Services Assistant on 07/01/25 that there was a mix up with the lab and another sample was obtained and sent to the lab for processing. -He did not know there were no orders from the PCP for the 06/24/25 or 07/01/25 urine sample. -The Care Services Assistant was responsible to notify the PCP or MHP for concerns about Resident #9's behavior or symptoms of a UTI. Attempted telephone interview with Resident #9's MHP on 07/03/25 at 8:30am and 10:30am, and 07/07/25 at 11:02am were not successful. 2. Review of Resident #6's current FL2 dated 03/11/25 revealed: -Diagnoses included dementia, hypertension, chronic renal failure stage 3 and obesity. -She was ambulatory. -She was continent of bowel and bladder. -Her level of care was a Special Care Unit (SCU). Observation of Resident #6 on 06/30/25 from 9:30am to 10:30am revealed she was sitting on the sofa in the common living room area with a sling on her left arm.	D 273		

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D 273	Continued From page 9 Interview with Resident #6 on 06/30/25 at 10:30 revealed: -She hurt her left arm a day or two ago. -She was to wear a sling but she did not know where it was. -He left arm hurt a little. Review of Resident #6's Accident/Incident Report dated 06/25/25 at 2:00am revealed: -Resident #6 was experiencing confusion and became aggressive with staff, stating she wanted to meet her family member at the front of the building, attempted to hit the door with a chair, and fell backwards. -Local Emergency Medical Services were called and Resident #6 was transported to the hospital. -There were no injuries reported at the time of the incident. -Resident #6's pain level was documented as a "6" on the PAINAD scale (a scale used on resident with advanced dementia who cannot verbalize pain well and 6 points were given for occasional labored breathing, short period of hyperventilation, occasional moan or groan, facial expression, body language of clinched fists, pulling or pushing away, striking out and distracted). -A post-accident fracture of the left arm was documented. Review of Resident #4's June 2025 progress notes revealed: -On 06/25/25 at 9:56am, the Care Services Assistant documented Resident #6 returned from the hospital with a diagnosis of a closed fracture to the top of the left humerus and a sling on the left arm. -On 06/25/25 at 10:05am, the Regional nurse documented Resident #6 returned from the hospital around 7:45am, with a sling applied to	D 273		

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D 273	Continued From page 10 her left arm and a fractured humerus as reported by the emergency personnel. -On 06/26/25 at 9:07pm, a MA documented Resident #6 was getting up from the dinner table, tripped and fell on her buttocks and rolled over on her right side. -Resident #6 did not complain of pain, assisted back into her chair and Resident #6's Power of Attorney (POA) refused for 911 to be called. Interview with a personal care aide (PCA) on 06/30/25 at 10:00am revealed: -Resident #6 was not wearing her sling because physical therapy (PT) was responsible for putting the sling on. -She did not know how to put on the sling or that she was supposed to because there was not a task in her Activities of Daily Living (ADL) electronic tablet on when and where to apply the sling. Interview with a second PCA on 06/30/25 at 10:40am revealed: -Resident #6 had a sling on her left arm as a result of a fall on 06/25/25. -PT was responsible for putting the sling on Resident #6. -There was no ADL task in her ADL electronic tablet for application of the sling, on which are or when it was to be applied, how long it was to be on or how to monitor it. Interview with a medication aide (MA) on 07/03/25 at 10:30am revealed: -On 06/25/25, Resident #6 returned to the facility from the hospital and she received report with the Regional Registered Nurse (RN) from the Emergency Medical Services staff. -Resident #6 was wearing a sling on her left arm because of a fractured left humerus.	D 273		

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D 273	Continued From page 11 -She was given the after-visit summary paperwork that had the diagnoses of a left arm humerus fracture and instructions about the sling application. -There was no order for the sling on when and where to apply the sling and what to monitor for or how long to wear it. -She did not call the PCP to get an order because the Regional RN was there as well and the RN did not have any questions. -The Care Services Assistant or RN was responsible to get orders from a provider if one was left off or needed. Interview with Resident #6's Primary Care Provider (PCP) on 07/01/25 at 10:45am and 11:36am revealed: -When Resident #6 did not wear her sling for her non-displaced humerus fracture, the risk for increased pain and displacement of the fracture increases because Resident #6 was not a good surgical candidate. -He did not know there was no order for Resident #6's sling and the staff were responsible to call him to get an order on when to apply, where to apply, how long to wear it and what to monitor for while wearing the sling. -He expected the staff to make sure the sling was on and correctly placed to help prevent/reduce the risk of injury that could lead to increased pain, displacement of the fractured left humerus which because bones take longer to heal in the elderly could result in death due to other complications caused from the fracture such as infection, osteomyelitis (infection of the bone) and deep vein thrombosis (DVT a blood clot that can travel to your lungs) which all can lead to death. Interview with the Care Service Assistant on 06/30/25 at 11:00am and 4:30pm revealed:	D 273			

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D 273	Continued From page 12 -On 06/25/25, Resident #6 fell and sustained a left arm humerus bone fracture. -She was to wear a sling on the left arm to help decrease pain and keep the fracture from displacing. -He did not know the staff did not apply the sling this morning. -The PCAs were responsible for applying the sling every morning and making sure it was on at all times and was to be documented on their ADL tablet as a task each shift. -The MAs were responsible for making sure the sling was applied correctly, remained on at all times and documented on the eMAR. Interview with the Care Services Assistant on 07/07/25 at 1:43pm revealed: -He did not know there was no order for Resident #6's left arm sling. -He and the Administrator was responsible for calling Resident #6's PCP to get an order for the sling to include when and where to apply the sling, how long to wear it and what and when to monitor for while wearing the sling. Interview with the Administrator on 07/07/25 at 2:22pm revealed: -He did not know Resident #6 did not have an order to instruct the staff about when and where to place the sling, how often and what to monitor for while wearing the sling, and when it was to be removed. -He or a designee was responsible to notify the PCP about the order because there was no order for the sling. 3. Review of Resident #2's current FL2 dated 04/08/25 revealed diagnoses included dementia, anxiety disorder and fall risk. Review of Resident #2's signed physician orders	D 273			

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NAME OF PROVIDER OR SUPPLIER THE HAVEN IN HIGHLAND CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 5920 MCCHESENEY DRIVE CHARLOTTE, NC 28269		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 13 dated 05/29/25 revealed an order for an HgbA1C (a laboratory test to monitor average blood sugar levels over the past 3 months) and lipid labs. Review of Resident #2's service care plan dated 09/17/24 revealed an admission date of 10/12/21. Interview with the Care Services Assistant on 07/02/25 at 4pm revealed: -He was aware tests to check Resident #2's HgbA1C and lipids were ordered on 05/29/25. -The HgbA1C and lipid labs for Resident #2 were not done. -He remembered the lab order was faxed to the facility's contracted laboratory on 05/29/25 but he did not have a fax confirmation from that date. -He re-faxed the lab order to the facility's contracted lab collection agency on 06/17/25 and he had a fax confirmation from that date. -A phlebotomist from the facility's contracted lab collection agency came to the facility to draw Resident #2's labs on an unknown date but documented the resident was no longer at the facility. -He and the Health and Wellness Director were responsible to ensure that orders were followed up and completed. -An order tracking book was initiated by the facility in June 2025 but it did not contain any lab orders for Resident #2. Interview with the Administrator on 07/02/25 at 12:50pm and 0707/25 at 2:35pm revealed: -The facility's part-time nurse and the Care Services Assistant were responsible for implementing all orders. -The facility "dropped the ball" on completing Resident #2's labs. -His expectation was that the labs would have been done as soon as possible.	D 273		

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D 273	Continued From page 14 The facility failed to ensure referral and follow up with a physician when an order was not obtained from Resident #6's PCP for a sling that was applied to her left arm by the emergency room when she was seen after she fell and sustained a non-displaced fracture of her left arm resulting in the staff not applying the sling or monitoring the sling's placement putting Resident #6 at risk for displacement of the fracture and for Resident #9 who had two urine samples collected after exhibiting increased behaviors, including striking another resident with a cane and chasing another with a butter knife. Resident #9's urine samples were not processed by the facility's contracted laboratory due to being collected without an order from the PCP. This failure was detrimental to the health, safety and well-being of the the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on July 28, 2025 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 21, 2025.	D 273		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;	D 344		

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D 344	Continued From page 15 (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to clarify medication orders for 1 of 9 sampled residents (#4) related to orders to discontinue medications used to regulate blood sugars, a medication used for hypertension, a medication used for constipation, a medication used for anxiety, and a medication used for pain. The findings are: Review of Resident #4's recent FL2 dated 10/16/24 revealed: -Diagnoses included dementia, diabetes, hypertension, congestive heart failure, and muscle weakness. -Resident #4's level of care was Special Care Unit. Review of Resident #4's physician orders dated 03/17/25 revealed: -Resident #4 had an order for lorazepam (used to treat anxiety) .5mg, one tablet by mouth as needed every 24 hrs, senna 8.6 one tablet every morning, Humalog (used to manage high blood sugar levels) solution 100 units, inject 5 units subcutaneously at dinner time for diabetes, terazosin HCl (used to treat high blood pressure) 10mg, 1 capsule by mouth at bedtime, and insulin glargine (used to manage blood sugar levels) solution 100 units, inject 12 units subcutaneously at bedtime, and blood sugar checks every	D 344		

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D 344	Continued From page 16 morning, notify physician of blood sugar less than 70 or greater than 400. Review of Resident #4's hospital discharge summary dated 6/12/25 revealed: -Resident #4 was seen in the ED on 6/5/25 due to a fall. -Resident #4 was admitted to the hospital due to acute kidney injury. -Resident #4 did not have any injuries because of fall and head injury. -Resident #4's head scan was negative. -Resident #4's medications were discontinued: lorazepam as needed, Lidocaine patch 5%, senna 8.6mg, terazosin HCl capsule 10mg, Humalog solution 100 units/ KwikPen (insulin lispro), and lantus solostar (insulin glargine) solution 100 units. Review of Resident #4's record revealed: -A progress note dated 06/12/25 revealed Resident #4 was discharged from the hospital and returned to the facility on 06/12/25. -A clarification request was faxed to Resident #4's Primary Care Provider (PCP) on 06/12/25 to clarify "stopped" medications (Humalog KwikPen, Lantus Solostar, terazosin, senna, lorazepam as needed, lidocaine patch as needed) that were discontinued on Resident #4's hospital discharge summary. -There was no documentation of a clarification response from the PCP until 06/16/25. -Resident #4 continued to receive scheduled medications that were discontinued on the hospital discharge summary, until 06/16/25. -Resident #4's medications that were discontinued at the time of hospital discharge were not discontinued at the facility until 06/17/25. Review of Resident #4's electronic medication	D 344			

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D 344	Continued From page 17 administration record (eMAR) for June 2025 revealed: -There was an entry for senna 8.6mg. -There was no documentation senna 8.6mg was discontinued on 06/12/25. -There was documentation senna 8.6mg was administered from 06/13/25 to 06/16/25. -There was an entry for terazosin HCl 10mg. -There was no documentation terazosin HCl 10mg was discontinued on 06/12/25. -There was documentation terazosin HCl 10mg capsules were administered from 06/12/25 to 06/16/25. -There was an entry for Humalog solution 100 units/ KwikPen. -There was no documentation Humalog solution 100 units/ KwikPen was discontinued on 06/12/25. -There was documentation Humalog solution 100 units/ KwikPen was administered from 06/12/25 to 06/16/25. -There was an entry for Lantus Solostar 100 units. -There was no documentation Lantus Solostar 100 units was discontinued on 06/12/25. -There was documentation Lantus Solostar 100 units was administered from 06/12/25 to 06/16/25. Interview with the medication aide (MA) on 07/03/25 at 10:43am revealed: -Resident #4 returned from the hospital on 06/12/25 and she administered his insulins, terazosin and other medications according to the eMAR orders. -She received report from the previous shift that a medication clarification request was sent to Resident #4's PCP and she did not know the outcome.	D 344		

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D 344	Continued From page 18 Interview with the facility Registered Nurse (RN) on 07/03/25 at 10:05am revealed: -She was asked to send a clarification of discontinued insulin medications to Resident #4's endocrinologist on 06/17/25. -She did not know if the endocrinologist sent a response to the facility because she only worked at the facility on Tuesdays. -She expected the facility to follow-up on the clarification request. Interview with the Care Services Assistant on 07/03/25 at 11:15am revealed: -He sent a medication clarification request to Resident #4's PCP on 06/12/25. -He consulted with the facility's corporate team and continued to wait for a clarification response from Resident #4's PCP. -He did not follow-up on the clarification request until 06/17/25 when a clarification request was sent to Resident #4's endocrinologist. -Resident #4's endocrinologist did not reply to the clarification. -Resident #4 continued to be administered both insulins, senna, as needed lorazepam, as needed lidocaine patch and terazosin until 06/17/25, despite the discontinued orders on the hospital discharge summary dated 06/12/25. Interview with the PCP on 07/03/25 at 2:42pm revealed a response to the medication clarification request was faxed to the facility on 06/16/25, recommending the facility to consult with Resident #4's endocrinologist who managed Resident #4's insulin. Interview with the Administrator on 07/02/25 at 12:55pm revealed: -He was not aware that a clarification response related to Resident #4's medications was not	D 344			

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D 344	Continued From page 19 received by Resident #4's PCP or endocrinologist. -He was not sure why the clarification was not discussed in morning stand-up meetings or interdisciplinary meetings held on Wednesday 06/13/25. -He expected the Care Services Assistant or part-time nurse to follow-up on receiving clarification of orders and he should have been notified that the clarification was not resolved.	D 344		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to administer medications as ordered for 1 of 9 sampled residents (#3) related to a medication used to treat hypertension. The findings are: 1. Review of Resident #3's current FL2 dated 02/18/25 revealed: -Diagnoses include dementia and hypertension. -She was constantly disoriented. -The recommended level of care was SCU. -There was an order for triamterene (used to treat high blood pressure) 37.5-25mg by mouth daily.	D 358		

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D 358	Continued From page 20 Review of Resident #3's Resident Register revealed an admission date of 06/01/23. Interview with Resident #3's family member on 07/01/25 at 11:32am revealed: -She was responsible for picking up medications for Resident #3 and bringing the medications to the facility. -Resident #3's triamterene (a medication used to lower blood pressure) 37.5-25mg was refilled and dispensed every 90 days. -She had not brought in any extra bottles of Resident #3's triamterene 37.5-25mg. -The facility did not document receipt of medications when she brought in Resident #3's medications. -On 04/11/25, she and the MA found three bottles of Resident #3's triamterene on the medication cart. -She and the MA counted Resident #3's triamterene 37.5-25mg on 04/11/25. -There were 15 tablets of triamterene 37.5-25mg available in bottle that was dispensed on 09/20/24. -There were 71 tablets of triamterene 37.5-25mg available in bottle that was dispensed on 12/20/24. -There were 90 tablets of triamterene 37.5-25mg available in bottle that was dispensed on 03/20/25. -She reported finding three bottles of Resident #3's triamterene 37.5-25mg to the Administrator and to the Regional Health and Wellness Director but there was no follow-up. Review of Resident #3's March 2025 eMAR revealed: -There was an entry for triamterene 37.5-25mg by mouth daily.	D 358			

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D 358	Continued From page 21 -Triamterene 37.5-25mg was documented as administered 03/01/25 through 03/31/25. Review of Resident #3's April 2025 eMAR revealed: -There was an entry for triamterene 37.5-25mg by mouth daily. -Triamterene 37.5-25mg was documented as administered 04/01/25 through 04/30/25. Review of Resident #3's May 2025 eMAR revealed: -There was an entry for triamterene 37.5-25mg by mouth daily. -Triamterene 37.5-25mg was documented as administered 05/01/25 through 05/31/25. Review of Resident #3's June 2025 eMAR revealed: -There was an entry for triamterene 37.5-25mg by mouth daily. -Triamterene 37.5-25mg was documented as administered 06/01/25 through 06/30/25. Observation of Resident #3's medications on hand on 07/01/25 at 12:24pm revealed: -There was a bottle of triamterene 37.5-25mg, with a dispense date of 12/20/24 in the quantity of 90 tablets with 7 tablets available for administration. -There was a bottle of triamterene 37.5-25mg, with a dispense date of 03/20/25 in the quantity of 90 tablets with 92 tablets available for administration. -There was a total of 101 tablets of triamterene 37.5-25mg available for administration. Telephone interview with a pharmacist with the facilities contracted pharmacy on 07/01/25 at 12:55pm revealed:	D 358		

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D 358	Continued From page 22 -Resident #3's triamterene 37.5-25mg was on cycle fill for every 90 days. -Resident #3's triamterene 37.5-25mg was dispensed on 09/20/24 in the quantity of 90 tablets. -Resident #3's triamterene 37.5-25mg was dispensed on 012/20/24 in the quantity of 90 tablets. -Resident #3's triamterene 37.5-25mg was dispensed on 03/20/25 in the quantity of 90 tablets. -Resident #3's triamterene 37.5-25mg was due to be dispensed in June 2025 but had not been picked up by her family member. -If Resident #3's triamterene 37.5-25mg had been given as ordered, there should not be any tablets left over unless otherwise documented by the facility. -If Resident #3 did not receive triamterene 37.5-25mg as ordered, she could experience a cardiovascular event, stroke or heart attack. Interview with a MA on 07/01/25 at 12:24pm and on 07/03/25 at 10:25am revealed: -The MAs contacted the family member when Resident #3 was low on medication and the family member would request the medication refill from Resident #3's pharmacy. -There was no process in place to document receipt of medications when obtained from outside pharmacies or from family members. -She and Resident #3's family member found three bottles of triamterene 37.5-25mg on the medication cart on April 2025. -She counted Resident #3's triamterene 37.5-25mg in front of the resident's family member in April 2025. -She did not know why Resident #3 had 101 extra tablets left to be administered. -She did not know why Resident #3 had 101	D 358		

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D 358	Continued From page 23 tablets of triamterene 37.5-25mg left for administration unless the MA's had not been administering the resident's triamterene 37.5-25mg along with her other medications. Interview with the Care Services Assistant on 07/02/25 at 4:08pm revealed: -Resident #3's family member made him aware of resident having three bottles of triamterene 37.5-25mg on the medication cart. -He did not complete any follow up with Resident #3's family member. -He did not complete a medication cart audit or count of Resident #3's triamterene 37.5-25mg. -He completed random med cart audits daily but only looked at expiration dates or if medications are low and needed refills. -The facilities contracted Pharmacy completed medication cart audits, but he did not know when or how often. -He did not know why Resident #3 had 101 tablets of triamterene 37.5-25mg left for administration. Interview with the Administrator on 07/02/25 at 1:03pm and on 07/07/25 at 2:22pm revealed: -Resident #3's family member made him aware of resident having three bottles of triamterene 37.5-25mg on the medication cart in April 2025. -Resident #3's family member did show him three bottles of Resident #3's triamterene 37.5-25mg. -He did not complete a count of Resident #3's triamterene 37.5-25mg because he had completed an audit of the resident's eMAR that showed the triamterene 37.5-25mg had been administered. -There was no system in place to document the receipt of medications when a family member or outside pharmacy provided medications. -He did not know why Resident #3 had 101	D 358			

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D 358	Continued From page 24 tablets of triamterene 37.5-25mg left for administration. -He, the Care Services Assistant and the Clinical Specialist completed random medication cart audits weekly but audits were not resident specific. -He expected the MAs to administer medications as ordered to residents and document on the eMAR accurately. Attempted telephone interview with Resident #3's PCP on 07/02/25 at 12:12pm was unsuccessful.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to notify the County Department of Social Services (DSS) of an accident that required emergency medical evaluation for 1 of 6 sampled residents (Resident #4) who had a fall and was transported to a local hospital by emergency medical services. The findings are:	D 451		

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D 451	Continued From page 25 Review of Resident #4's recent FL2 dated 10/16/24 revealed: -Diagnoses included dementia, diabetes, hypertension, congestive heart failure, and muscle weakness. -Resident #4 had constant confusion. -Resident #4 was semi ambulatory and used a walker. -Resident #4 was incontinent of bladder and bowel. -Resident #4 required assistance with eating cues, bathing, and dressing. -Resident #4's level of care was Special Care Unit. Review of Resident #4's care plan dated 2/6/25 revealed: -Resident #4 was at risk for falls. -Resident #4 had wandering behaviors. -Resident #4 required assistance with all activities of daily living (ADLs). Review of Resident #4's incident and accident report dated 6/5/25 revealed: -Resident #4 was found on the floor in his room outside his bathroom. -Resident #4 was able to state he hit his head when he fell and experienced pain to the back of his head. -The Emergency Medical Services (EMS) was contacted and Resident #4's family member were notified. -Resident #4 was transported to the emergency department (ED) by EMS. -There was no documentation that the Department of Social Services (DSS) was notified. Telephone interview with the Adult Home	D 451		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060162	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/07/2025
NAME OF PROVIDER OR SUPPLIER THE HAVEN IN HIGHLAND CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 5920 MCCHESENEY DRIVE CHARLOTTE, NC 28269		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 451	Continued From page 26 Specialist Supervisor for DSS on 07/01/25 at 9:05am revealed DSS did not receive an incident and accident report for Resident #4, who was sent to the ED due to a fall on 06/05/25. Interview with the Care Services Assistant on 07/3/25 at 11:15am revealed: -He and designated staff were responsible for completing incident and accident reports and submitting them to the Health and Wellness Director or Administrator. -He was not responsible for sending incident and accident reports to DSS. -The previous Administrator would have been responsible for sending Resident #4's fall report dated 06/05/25. -He checked the facility fax transmissions from June and July and could not locate any documentation that Resident #4's incident and accident report had been sent to DSS. Interview with the Administrator on 07/3/25 at 11:45am revealed: -He was on vacation when Resident #4 had a fall on 06/05/25 and was sent to the hospital. -The previous Administrator would have been responsible for sending Resident #4's fall report to DSS. -Incident and accident reports were usually completed by medication aides (MA) and turned into the HWD or Administrator. -He or his designee are currently responsible for sending incident and accident reports to DSS.	D 451			
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training	D 468			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060162	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/07/2025
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D 468	Continued From page 27 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 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: FOLLOW UP TO TYPE A1 VIOLATION The Type A1 Violation was abated and non-compliance continues. Based on record reviews and interviews, the facility failed to ensure that 2 of 4 sampled staff, (Staff B and Staff D) completed 6 hours of orientation on the nature and needs for the residents of the Special Care Unit (SCU) within	D 468			

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D 468	Continued From page 28 the first week of employment. The findings are: Review of the facility's current license dated 01/01/25 revealed the facility was licensed as an Alzheimer's/Dementia SCU with a capacity of 60 residents. Review of the facility's current census on 06/30/25 revealed there was a total of 36 residents. 1. Review of Staff B's personal care aide (PCA) personnel record revealed: -The facility did not have a personnel record available for Staff B upon request on 07/03/25. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff B. Attempted telephone interview with Staff B on 07/02/25 at 2:15pm was unsuccessful. Refer to the interview with the facilities contracted Staffing Agency on 07/03/25 at 2:24pm. Refer to the interview with the Administrator on 07/03/25 at 11:54am. 2. Review of Staff D's PCA personnel record revealed: -The facility did not have a personnel record available for Staff D upon request on 07/03/25. -There was no documentation of 6-hour orientation on the nature and needs of the SCU residents for Staff D. Interview with Staff D on 07/03/25 at 10:44am revealed:	D 468		

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NAME OF PROVIDER OR SUPPLIER THE HAVEN IN HIGHLAND CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 5920 MCCHESENEY DRIVE CHARLOTTE, NC 28269		
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D 468	Continued From page 29 -She was employed through the facility's contracted staffing agency. -She had been working at the facility as a PCA for about two weeks. -She had received dementia specific training through the staffing agency but did not know how many hours. -Since she started working at the facility, she did not receive any training related to SCU orientation and care needs of the SCU residents other than staff showing her how to use the facility, resident care tablet. Interview with the facilities contracted Staffing Agency on 07/03/25 at 2:24pm revealed: -The Staffing Agency employed PCAs (Staff B and D) at the facility after obtaining a clean background check and completing a 7-hours of training that included infection control, overview of food and nutrition, mobility and equipment assistance, personal care through activities of daily living, client rights, HIPPA, elder abuse prevention and 1-hour of introduction to dementia care. -The Staffing Agency does not check their newly hired employees against the Health Care Personnel Record (HCPR). Interview with the Administrator on 07/03/25 at 11:54am revealed: -He did not know the facility had to keep personal records on every employee even if contracted through a staffing agency. -He was aware staffing agency staff were required to have a minimum of 6 hours of SCU orientation within the first week of employment. -He thought all training had been completed by the agency.	D 468		