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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060163	A. BUILDING: _____ B. WING _____	C 06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN IN THE VILLAGE AT CAROLINA PLACE	13150 DORMAN ROAD PINEVILLE, NC 28134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 06/09/21-06/10/21 with a desk review on 06/11/21 an exit conference via telephone on 06/14/21.	D 000		
D 087	10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following: (A) at least one pillow with clean pillow case; (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings as needed; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain a mattress in good repair for 1 of 3 sampled residents related to a mattress with multiple black stains on the mattress (Resident #1). The findings are:	D 087	The Havens at Carolina Place – SOD Dated 7/6/2021 1) 10A NCAC 13F.0306(b)(1) Housekeeping and Furnishings – "Based on observations and interviews, the facility failed to maintain a mattress in good repair for 1 of 3 sampled residents related to a mattress with multiple black stains on the mattress (Resident #1)." A) The alleged deficient practice will be/ has been corrected for the listed residents by taking the following action: Resident #1 has been discharged based upon his need for a higher level of care related to behavioral and supervision needs. B) Other residents potentially affected by the same alleged deficient practice will be identified as follows: All residents have the potential to be affected. On July 16th, an audit was completed of all other resident mattresses and repairs or replacements will be made for any necessary mattresses. C) The following systemic changes will be made to ensure compliance with this regulation: All staff will be in-serviced on appropriate mattress appearance and required bed coverings no later than 8/18/21. D) The facility will monitor the corrective action as follows: Maintenance Director/ designee will complete weekly mattress audits x 4 weeks and then monthly x 4 months.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: RDO — (X6) DATE: 8/24/21

STATE FORM 6899 LB6Y11 If continuation sheet 1 of 51

Reviewed and Acknowledged on 08/30/21 by MA

Mary R. Agena

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D 087	Continued From page 1 Review of Resident #1's current FL2 dated 07/21/20 revealed: -Diagnoses included dementia, anxiety hypertension, restless leg syndrome, lymphocytosis and glaucoma. -He was constantly disoriented and had wandering behaviors. -Resident #1 was ambulatory and the current level of care was documented as the special care unit (SCU). Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 07/13/20. Observation of Resident #1's bed on 06/10/21 at 10:40am revealed: -The pillow on the bed was without a pillowcase. -The mattress pad was shredded in multiple places. -The mattress contained multiple black stains on the top of the mattress and without odors. Telephone interview with Resident #1's family member on 06/10/21 at 8:40am revealed: -She provided a mattress, 2 sets of sheets, 2 pillows, 2 blankets and 2 mattress pad covers on admission on 07/13/20. -In December 2020, the Administrator called her and told her she needed to buy a new hospital bed because it would have side rails, a mattress and coverings for Resident #1's bed because the mattress was messed up and there were no sheets for the bed. -In December 2020, she bought a new pillow top mattress that was approved by Resident #1's primary care physician for good body support, 2 sets of sheets, 2 pillows, 2 blankets and 2 mattress pad covers. -About a week later she visited Resident #1, his	D 087		

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D 087	Continued From page 2 bed did not have sheets or mattress pad on it and the mattress had a few black stains on it. -The Administrator informed her that she needed to replace the second mattress. -She told the Administrator to have the staff use the sheets and mattress pad coverings she bought in order to protect the second mattress so that it would not become worse. -Over then next few months when she visited, she would find the bed without a mattress pad or sheets and the mattress became more soiled because the staff were failing to use the sheets and mattress pads on the mattress. -She informed the Administrator many times but was continually told to replace the mattress. -She expected the facility to use the mattress pads along with the sheets so Resident #1 could only soil the mattress pads. -Instead, the mattress pads were not used every time and the mattress became soiled. Interview with the Administrator on 06/10/21 at 11:00am revealed: -The personal care aides (PCA) were responsible for the resident's laundry and notification to her for any concerns or issues with the resident's linens and mattresses. -In December 2020 Resident #1's mattress became soiled and required a new one. -Because the facility supplied the first mattress when Resident #1 was admitted, and Resident #1 soiled the first one she required the family to supply the replacement mattress. -She notified Resident #1's family about the need for another mattress, sheets, mattress pad and pillows and were to be supplied by Resident #1's family. -She was not aware the initial mattress had been replaced in December 2020 by Resident #1's family member.	D 087		

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D 087	Continued From page 3 -She was informed about the stains on Resident #1's second mattress but thought it was the original mattress he was provided when Resident #1 was admitted and was never replaced and that was why she required the family replace the mattress. -Resident #1's family was responsible for replacing all mattresses and linens when they became soiled. -It was not the responsibility of the facility staff to replace soiled mattresses. -She expected the staff to use the mattress pad on the resident's mattresses in order to protect the mattress. -Resident #1 was incontinent at times and his bed linens were to be washed after every episode and the staff were to keep Resident #1's bed made at all times. -She did not check back with the staff to confirm the initial mattress was replaced or if the staff were using the mattress pad and the bed was always made.	D 087		
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: Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents, related to a resident with persistent behaviors including wandering and urinating in inappropriate places (Resident #1).	D 270	The Havens at Carolina Place – SOD Dated 7/6/2021 2) 10A NCAC 13F.0901(b) Personal Care and Supervision – "Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents, related to a resident with persistent behaviors including wandering and urinating in inappropriate places (Resident #1)." A) The alleged deficient practice will be/ has been corrected for the listed residents by taking the following action: Resident #1 has been discharged based upon his need for a higher level of care related to behavioral and supervision needs. B) Other residents potentially affected by the same alleged deficient practice will be identified as follows: All residents have the potential to be affected. Director of Resident Care/ Designee will complete an audit of all behavior logs for residents with orders for behavior logs no later than 8/18/21. C) The following systemic changes will be made to ensure compliance with this regulation: All Medication Technicians, who complete the behavior logs, will be in-serviced on appropriate supervision and completion of behavior logs no later than 8/18/21. D) The facility will monitor the corrective action as follows: Director of Resident Care/ designee will complete audits of behavior logs weekly x 4 weeks, then monthly x 4 months.	

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D 270	Continued From page 4 The findings are: Review of Resident #1's current FL2 dated 07/21/20 revealed: -Diagnoses included dementia, anxiety hypertension, restless leg syndrome (RLS), lymphocytosis and glaucoma. -He was constantly disoriented and had wandering behaviors. -Resident #1 was ambulatory and the current level of care was documented as the special care unit (SCU). Review of the facility Special Care Unit Resident Profile for Resident #1 dated 05/28/21 revealed: -The behavior patterns documented were; wandering, paranoid/delusions, agitation/aggressions, sundowning, disruptive behaviors and others. -The degree of cognition documented were; a lack of orientation to person, place or time, and impaired short and long term memory. -Resident #1 required redirection and cueing. Review of Resident #1's Behavioral Logs for February 2021 revealed: -On 02/01/21, 11:00pm to 7:00am shift. The behavior area and the successfulness area were blank. -On 02/02/21, 11:00pm to 7:00am shift, the behaviors documented were Resident #1 was up most of the night walking up and down. The redirection and successfulness area was blank. -On 02/03/21, 11:00pm to 7:00am shift, the behaviors documented for Resident #1 was up all night, peed every where in the whole room. The redirection and successfulness area was blank. -On 02/04/21, 11:00pm to 7:00am shift, the behaviors documented for Resident #1 was up all	D 270		

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D 270	Continued From page 5 night, going into every room and turning on the lights for every room. The redirection and successfulness area was blank. -On 02/06/21, 11:00pm to 7:00am shift, the documented behaviors were Resident #1 was up all night, peeing every where and going into every room. The redirection and successfulness area was blank. -On 02/07/21, 11:00pm to 7:00am shift, the documented behaviors were Resident #1 was up all night. The redirection and successfulness area was blank. There were no Behavioral Logs for Resident #1 for the months of March and April 2021 available for review. Review of Resident #1's Behavioral Logs for May 2021 revealed: -On 05/04/21, the shift area was blank, the behavior was documented as "no abnormal behavior" and the redirection and successfulness area was blank. -On 05/04/21, 3:00pm to 11:00pm shift, the behavior area was blank and the redirection and successfulness area was documented as "no". -On 05/05/21, 3:00pm to 11:00pm shift, the behavior was documented as "walking in other rooms, redirected out of rooms" and the redirection and successfulness area was documented as "some". -On 05/09/21, 3:00pm to 11:00pm shift, the behavior area was documented as "cannot sit still during dinner, going into other resident's rooms taking their belongings out of their room, tearing signs off the door, pulling linens's off the beds, and taking clothes out of the closet. The redirection and successfulness was documented as "no". -On 05/09/21, 3:00pm to 11:00pm shift, the	D 270		

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D 270	Continued From page 6 behavior was documented at " putting his fingers" in a resident's plate and slept all night. The redirection and successfulness was documented as "no". -On 05/20/21, the behaviors noted were documented as "none noted and slept a lot". The redirection and successfulness area was blank. -On 05/57/21, 7:00am to 3:00pm shift, the behaviors noted were documented as "none noted". The redirection and successfulness area was blank. -On 05/29/21, 7:00am to 3:00pm shift, the behaviors documented were "pleasantly confused, no medication required when noted resident from room to room, sitter observing very closely". The redirection and successfulness area was blank. There were no Behavioral Logs for Resident #1 for the month of June 2021 available for review. Review of Resident #1 Incident/Accident Report dated 05/27/21 revealed: -On 05/27/21, an incident report was filled out for an incident that occurred on 05/24/21. -The incident which occurred on 05/24/21 was documented as, "failure to perform resident checks". -The incident on 05/24/21 reported to the facility on 05/27/21 by the other resident's family member's video/audio recording device located in the other resident's room. -The failure to perform resident checks on 05/24/21 resulted in Resident #1 located in another resident's room for 4-1/2 hours. -There was no injury documented on 05/24/21 to either one of the residents involved. Review of #1's PCP office visit notes dated 05/25/21 revealed:	D 270		

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D 270	Continued From page 7 -The PCP attended an Interdisciplinary Team (IDT) meeting at the facility. -Informed Resident #1's family, IDT team, including the Ombudsman about Resident #1's frail condition and physical functioning status in the setting of dementia of Alzheimer's type versus mixed dementia with moderate to severe degree of cognitive impairment, bilateral visual impairment, and BPH contributing to abnormal behaviors and overall Resident #1's sensitivity in the terms of side effects from a medication standpoint are not completely reversible. -Informed Resident #1's family, Ombudsman and IDT team, that Resident #1's overall sensitivity to pharmacological management with his conditions, increased the risk of falls. -Resident #1 had non-pharmacological interventions in his MAR which needed to be followed by the staff for Resident #1's abnormal behavior which includes getting up in the middle of the night and ambulating. -During the physical examination, Resident #1 was Alert, cooperative, and appropriate with mood and affect. -At present Resident #1 was medically stable and continue to monitor Resident #1's abnormal behavior with non-pharmacological interventions in place. Telephone interview with the Resident Service Director (RSD) on 06/14/21 at 10:08am revealed: -The normal supervision in the Special Care Unit was for staff to observe the resident every 2 hours. -In certain circumstances, increased supervision would be required. -Resident #1 was placed on 1 on 1 supervision after it was reported to her and the Administrator, Resident #1 was in another resident's room for 4-1/2 hours.	D 270		

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D 270	Continued From page 8 -On 05/27/21, it was the decision of her and the Administrator to place Resident #1 on 1 on 1 supervision, 24/7. Review of the Resident #1's facility progress notes revealed on 05/27/21, the RSD placed Resident #1 on 1 on 1. Review of Resident #1's facility Resident Evaluation and Behavioral Care Plan dated 05/28/21 revealed: -The reason for the evaluation was for a significant change. -Resident #1 was a fall risk and required staff to monitor for falls daily and a 1 on 1 was in place on 05/28/21. -The fall risk/safety intervention was to provide 1 on 1 supervision, and to redirect Resident #1 from entering other resident's rooms. -Resident #1 was dependent on caregivers for all continence management needs and required assistance every 2 hours. -Resident #1 was cognitively impaired and the task required for this was 1 on 1 care and required supervision and redirection. -Resident #1 was on 1 on 1 constant supervision since 05/27/21 and provided verbal redirection. Telephone interview with Resident#1's family member on 06/10/21 at 8:40am revealed: -She was informed by the RSD Resident #1 was on 1 on 1 supervision starting 05/27/21 because of his behaviors on 05/24/21 resulting in the need for increased supervision. -She was told she had to call and provide the 1 on 1 care. -She told the RSD, they were the health care professionals and she did not know who to call to obtain a sitter. -She was told by the RSD the facility would	D 270		

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D 270	Continued From page 9 provide the sitter. -She visited Resident #1 every Saturday from 1:00pm to 2:00pm. -She visited Resident #1 on 05/29/21 and 06/05/21 and there was no 1 on 1 sitter for Resident #1. Observation of Resident #1 on 06/09/21 from 9:00am to 11:20am revealed: -At 9:00am Resident #1 was laying in his bed and no staff in the room with him or outside his door. The door to his room was closed. -At 9:30am Resident #1 was laying in his bed and no staff in the room with him or outside his door. The door to his room was closed. -At 10:15am Resident #1 was laying in his bed and no staff in the room with him or outside his door. The door to his room was closed. -At 10:45am Resident #1 was laying in his bed and no staff in the room with him or outside his door. The door to his room was closed. -At 11:20am Resident #1 was laying in his bed and no staff in the room with him or outside his door. The door to his room was closed. -At 11:30 a personal care aide (PCA) got Resident #1 up and helped him to the dining room table. Review of May 2021 facility shift reports revealed: -There were no facility shift reports for 05/01/21 to 05/24/21 and 05/26/21 available for review. -On 05/25/21, there was no documentation for Resident #1 on the shift report. -On 05/27/21, Resident #1 was 1 on 1 until further notice. -On 05/28/21, Resident #1 was on 1 on 1 at all times. -On 05/29/21, Resident #1 was to have a sitter at all times. -On 05/30/21, Resident #1 was to have sitter at	D 270		

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D 270	Continued From page 10 all times. Interview with a PCA on 06/09/21 at 2:55pm revealed: -It was her first day at the facility and she was an agency PCA. -During the morning meeting she was assigned to Resident #1's hall as the only PCA on 06/09/21. -At 11:30am, on 06/09/21, the medication aide (MA) informed her she was to provide 1 on 1 supervision to Resident #1. -That was the first she was told about Resident #1 requiring 1 on 1 supervision. -She was not told she needed to provide documentation on Resident #1. -She was not aware of a behavioral log for Resident #1. Interview with the Licensed Practical Nurse (LPN) on 06/09/21 at 3:00pm revealed: -She thought Resident #1 was on 1 on 1 supervision but there was not an assignment for a sitter on 06/09/21 until 11:30am when the RSD told a PCA to do the 1 on 1 supervision of Resident #1. -She had not observed Resident #1 on 1 on 1 supervision before. Interview with a second LPN on 06/09/21 at 3:40pm revealed: -For the normal resident safety checks the staff were required to check in on the residents every two hours. -The facility placed Resident #1 was on 1 on 1 supervision since the end of May 2021 because he was in a resident's room for 4-1/2 hours last month. -The RSD informed her the 1 on 1 was for increased supervision and for someone to keep him from wandering, which you could not do.	D 270		

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D 270	Continued From page 11 -She considered wandering "normal" for dementia residents. -Resident #1 never hurt anyone, was always kind, just confused. -Out of the 4 shifts she worked since 06/01/21, there was only time someone performed 1 on 1 with Resident #1. Telephone interview with the Resident Care Coordinator on 06/14/21 at 11:55am revealed: -Resident #1 was on 1 on 1 supervision with staff assigned to Resident #1 every shift every day and the staff assigned to Resident #1 were to supervise Resident #1 and no other duties were to be assigned to that person. -She was not aware Resident #1 did not have the 1 on 1 supervision every day every shift since 05/27/21. -The RSD was responsible for making the assignments for the month which included staff who would perform the one on one supervision for Resident #1. -She was responsible for making sure the one on one supervision was completed. -She did not check to make sure the one on one supervision was completed. Interview with the Administrator on 06/10/21 at 10:30am revealed: -On 05/27/21, she received a phone call from another resident's family. -The family member informed her Resident #1 was in her mother's room on 05/24/21 for 4-1/2 hours and thought they needed to know. -The family had a video/audio recording device in her mother's room and saw the video on the morning of 05/25/21. -The family member did not call until 05/27/21 because they did not feel mom was in danger. -She notified the PCP and asked for medication	D 270		

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D 270	Continued From page 12 to help control Resident #1's behaviors and was told no by the PCP. -She considered wandering a "normal" behavior for dementia residents who would require increased supervision for that behavior but Resident #1 had excessive wandering and now required 1 on 1 supervision. -She ordered 1 on 1 supervision for Resident #1 on 05/27/21, 24/7. -She did not know Resident #1 did not receive one on one supervision. -She was informed by the RSD on 05/27/21, Resident #1 was placed on one one one supervision. -The RSD was responsible for assigning staff for Resident #1 to provide one on one supervision 24/7 effective 05/27/21. -On 05/27/21, she considered the behaviors Resident #1 exhibited on 05/24/21 and previous behaviors as "disruptive" even though the other family member was not concerned.	D 270	The Havens at Carolina Place – SOD Dated 7/6/2021 3) 10A NCAC 13F.0902(c)(3-4) Health Care – "Based on observations, interviews, and record reviews, the facility failed to implement an order for 1 of 3 sampled residents, (Resident #1)." A) The alleged deficient practice will be/ has been corrected for the listed residents by taking the following action: Resident #1 has been discharged based upon his need for a higher level of care related to behavioral and supervision needs. B) Other residents potentially affected by the same alleged deficient practice will be identified as follows: All residents have the potential to be affected. Director of Resident Care/ Designee will complete an audit of all behavior logs for residents with orders for behavior logs no later than 8/18/21. C) The following systemic changes will be made to ensure compliance with this regulation: All Medication Technicians, who complete the behavior logs, will be in-serviced on appropriate supervision and completion of behavior logs no later than 8/18/21. D) The facility will monitor the corrective action as follows: Director of Resident Care/ designee will complete audits of behavior logs weekly x 4 weeks, then monthly x 4 months.	
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.	D 276		

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D 276	Continued From page 13 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement an order for 1 of 3 sampled residents, related to a resident with orders to monitor and document behaviors during episodes of increased wandering, and behaviors including urination in other residents' rooms and behaviors where redirection was not effective in (Resident #1). The findings are: Review of the facility's Behavior Guidelines and Analysis policy dated 08/01/18 revealed: -Individuals with Alzheimer's disease or related disorders are not cognizant of their behaviors due to irreversible changes in the brain. -Well trained caregivers can help manage behaviors through appropriate interventions. -The first step was to identify the problem. -An incident report was to be completed when aggressive behavior is aimed or targeted towards another person. -Behavioral reviews were to be conducted when a behavior was identified. -The Resident Service Director (RSD) was to review all incident reports. -The RSD was to investigate any behaviors and take action. -The RSD was to identify interventions and add them to the service plan and review with the staff. -The RSD was responsible for reviewing behaviors for trends and patterns on a monthly basis. -At the end of every month the RSD completed an incident/accident/behavior analysis. -If a trend or pattern was identified, the RSD and	D 276		

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D 276	Continued From page 14 the staff initiated appropriate interventions. Review of Resident #1's current FL2 dated 07/21/20 revealed: -Diagnoses included dementia, anxiety hypertension, restless leg syndrome, lymphocytosis and glaucoma. -He was constantly disoriented and had wandering behaviors. -Resident #1 was ambulatory and the current level of care was documented as the special care unit (SCU). Review of the facility Special Care Unit Resident Profile for Resident #1 dated 05/28/21 revealed: -The behavior patterns documented were: wandering, paranoid/delusions, agitation/aggressions, sundowning, disruptive behaviors and others. -The degree of cognition documented were; a lack of orientation to person, place or time, and impaired short and long term memory. -Resident #1 required redirection and cueing. -Resident #1 required total assistance with grooming, bathing and toileting. -This was a change related to increased behaviors and care plan meeting held on 05/25/21. Review of Resident #1 signed physician's orders revealed: -There was an order dated 02/04/21 for a Behavior Log, to document abnormal behavior, time of day, and use of non-pharmacological interventions, document intervals education, intensity of behaviors, and document efficacy. -There was an order dated 03/02/21 for a Behavior Log, to document abnormal behavior, time of day, and use of non-pharmacological interventions as mentioned in the Medication	D 276		

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D 276	Continued From page 15 Administration Record (MAR), document intervals, education, intensity of behaviors, and document efficacy. Telephone interview with Resident #1's PCP on 06/11/21 at 9:40am revealed: -He worked with Resident #1's family member to create a list of non-pharmacological interventions that were effective for resident #1. -He provided the facility the non-pharmacological interventions and discussed this list with the RSD. Review of Resident #1's non-pharmacological interventions list provided with the orders dated 02/04/21 and 03/02/21 revealed: -Resident #1 liked to walk around at night due to restless legs and bad knees. Yelling at him to return to his room would not work, best to let him walk for a few minutes and he would return to his room. -Resident #1 would need to be prompted. -If Resident #1 talked about getting out of the facility and when he was leaving, remind him he was there for 3-4 weeks for rehabilitation per the doctor's orders and it was covered by his insurance. -Resident #1 was a retired police officer, so that was always a good conversation to start to redirect. Review of Resident #1's Primary Care Physician (PCP) visit notes dated 01/05/21 revealed: -Resident #1 had a Montreal cognitive assessment completed with a score of 15/30 (a score of less than 26 was considered cognitively impaired). -Resident #1 had an overall moderate degree of cognitive impairment with deficits in memory, orientation, verbal fluency, and frontal executive/problem solving.	D 276		

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D 276	Continued From page 16 -Resident #1 had abnormal behaviors including wandering in the nighttime and going into other resident's rooms, but at present per the staff had been easily redirected. -The facility staff had reported Resident #1 being up all night again but there had been no documentation to accurately comment on the intensity of this problem. -The course of action taken was to continue to monitor for abnormal behaviors, discussion of the non-pharmacological interventions which had been put in place with the MAR for the medication aides (MA) and personal care aides (PCA) to use. Review of Resident #1's PCP visit notes dated 01/12/21 revealed: -During the physical examination, Resident #1 was alert, cooperative, and appropriate with mood and affect. -The plan was to continue with the behavioral log. -The facility nursing staff were to coordinate a care plan meeting with Resident #1's family member regarding current level of care and other options available in the addition to behavioral log for close monitoring on Resident #1's abnormal behavior. -Resident #1's behavior log was reviewed since last week and there were 2 times documented Resident #1 walked around all day. -The plan of care was discussed on the phone with Resident #1's family member and the facility's Licensed Practical Nurse (LPN). Review of Resident #1's PCP visit notes dated 02/16/21 revealed: -During the physical examination, Resident #1 was alert, cooperative, and appropriate with mood and affect. -Resident #1 had an overall moderate degree of cognitive impairment with deficits in memory,	D 276		

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D 276	Continued From page 17 orientation, verbal fluency, and frontal executive/problem solving. -Resident #1 had abnormal behavior including wandering in the nighttime and going into other residents' rooms but at present per the staff Resident #1 was redirectable. -Resident #1 had non-pharmacological interventions in his MAR which needed to be followed by the staff for Resident #1's abnormal behavior which included getting up in the middle of the night and ambulating. -At present, the PCP recommended to continue using non-pharmacological interventions and document the effectiveness of that approach before he tried further pharmacological interventions. -The PCP discussed with the staff to document in the non-pharmacological interventions in the MAR and educate the staff on the same to help Resident #1 with abnormal behaviors which includes wandering in the hall during the night and when going into other residents' rooms. Review of Resident #1's PCP office note dated 03/30/21 revealed: -At present, we will continue to monitor for abnormal behaviors. -Non-pharmacological interventions and MAR were in place. Review of Resident #1's PCP office visit note dated 05/18/21 revealed: -Resident #1 had behavioral and psychological symptom of dementia. -Resident #1 continued to have behaviors which involved Resident #1 walking in and out of his room during the nighttime. -Non-pharmacological interventions and MAR were in place. -Resident #1 had urinary incontinence with	D 276		

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D 276	Continued From page 18 benign prostatic hyperplasia (BPH, an enlarged prostate) which kept Resident #1 up during the nighttime, wandering into other residents' rooms secondary to Resident #1's impaired vision and cognitive impairment. -He would continue to monitor Resident #1's abnormal behavior with non-pharmacological interventions Review of #1's PCP office visit notes dated 05/25/21 revealed: -The PCP attended an Interdisciplinary Team (IDT) meeting at the facility. -He informed Resident #1's family, IDT team, including the Ombudsman Resident #1's behaviors were not completely reversible given Resident #1's frail condition and physical functioning status in the setting of dementia of Alzheimer's type versus mixed dementia, bilateral visual impairment, and BPH contributing to abnormal behaviors and Resident #1's overall sensitivity to medications. -He informed Resident #1's family, Ombudsman and IDT team, that Resident #1's overall sensitivity to pharmacological management with his conditions, increased the risk of falls. -Resident #1 had non-pharmacological interventions in his MAR which needed to be followed by the staff for Resident #1's abnormal behavior. -During the physical examination, Resident #1 was alert, cooperative, and appropriate with mood and affect. -At present, Resident #1 was medically stable and continue to monitor Resident #1's abnormal behavior with non-pharmacological interventions in place. -There were no new recommendations. Review of Resident #1's facility Resident	D 276		

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D 276	Continued From page 19 Evaluation/Behavioral Care Plan dated 05/28/21 revealed: -The reason for the evaluation was for a significant change. -Resident #1 was a fall risk and required staff to monitor for falls daily. -The fall risk/safety intervention was to redirect Resident #1 from entering other resident's rooms. -Resident #1 was cognitively impaired and the task required for this was to monitor behaviors and required supervision and redirection. -Resident #1's interventions in place for wandering included documentation by the facility staff of any behaviors and attempted interventions to provide for Resident #1. Review of Resident #1's April 2021 MAR revealed: -There was an entry for a Behavior Log, to document abnormal behavior, time of day, and use of non-pharmacological interventions, document intervals, education, intensity of behaviors, and document efficacy documented 04/01/21 to from 04/30/21 at 7:00am to 3:00pm, 3:00pm to 11:00pm and 11:00pm to 7:00am, 59 out of 90 opportunities. -There was no documentation of any non-pharmacological interventions implemented or the effectiveness of the interventions. Review of Resident #1's May 2021 MAR revealed: -There was an entry for a Behavior Log, to document abnormal behavior, time of day, and use of non-pharmacological interventions, document intervals, education, intensity of behaviors, and document efficacy documented from 05/01/21 to 05/31/21 at 7:00am to 3:00pm, 3:00pm to 11:00pm and 11:00pm to 7:00am, 93 out of 93 opportunities.	D 276		

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D 276	Continued From page 20 -There was no documentation of any non-pharmacological interventions implemented or the effectiveness of the interventions. Review of Resident #1's June 2021 MAR revealed: -There was an entry for a Behavior Log, to document abnormal behavior, time of day, and use of non-pharmacological interventions, document intervals, education, intensity of behaviors, and document efficacy documented from 06/01/21 to 06/10/21 at 7:00am to 3:00pm, 3:00pm to 11:00pm and 11:00pm to 7:00am, 18 out of 28 opportunities. -There was no documentation of any non-pharmacological interventions implemented or the effectiveness of the interventions. Review of Resident #1's Behavioral Logs for February 2021 revealed: -There was one column for staff to document abnormal behaviors and a second column to document the intervention utilized and its effectiveness. -On 02/01/21, 11:00pm to 7:00am shift the behavior area and the successfulness area were blank. -On 02/02/21, 11:00pm to 7:00am shift, Resident #1 was up most of the night walking up and down. The second column was left blank. -On 02/03/21, 11:00pm to 7:00am shift, Resident #1 was up all night, urinated "everywhere in the whole room". The second column was left blank. -On 02/04/21, 11:00pm to 7:00am shift, Resident #1 was up all night, going into every room and turning on the lights for every room. The second column was left blank. -On 02/06/21, 11:00pm to 7:00am shift, Resident #1 was up all night, urinating everywhere and going into every room. The second column was	D 276		

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D 276	Continued From page 21 left blank. -On 02/07/21, 11:00pm to 7:00am shift, the documented behaviors were Resident #1 was up all night. The second column was left blank. There were no Behavioral Logs for Resident #1 for the months of March and April 2021 available for review. Review of Resident #1's Behavioral Logs for May 2021 revealed: -On 05/04/21, the shift area was blank, Resident #1 had "no abnormal behavior" and the second column was left blank. -On 05/04/21, 3:00pm to 11:00pm shift, the behavior area was blank and the second column was area was documented as "no". -On 05/05/21, 3:00pm to 11:00pm shift, the behavior was documented as "walking in other rooms, redirected out of rooms" and the second column was documented as "some". -On 05/09/21, 3:00pm to 11:00pm shift, the behavior area was documented as "cannot sit still during dinner, going into other resident's rooms taking their belongings out of their rooms, tearing signs off the door, pulling linens off the beds, and taking clothes out of the closet. The second column was documented as "no". -On 05/09/21, 3:00pm to 11:00pm shift, the behavior was documented at "putting his fingers" in a resident's plate and slept all night. The second column was documented as "no". -On 05/20/21, the behaviors were documented as "none noted and slept a lot". The second column was left blank. -On 05/57/21, 7:00am to 3:00pm shift, the behaviors noted were documented as "none noted". The redirection and successfulness area was blank.	D 276		

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D 276	Continued From page 22 -On 05/29/21, 7:00am to 3:00pm shift, the behaviors documented were "pleasantly confused, no medication required when noted resident from room to room, sitter observing very closely". The second column was left blank. Review of the Resident #1's facility progress notes revealed: -On 05/18/21, medication aide (MA) reported to the RSD about a dime sized purple area to his left lower cheek. -On 05/19/21, the police were called related to the bruise and Resident #1 reported to the police, "he was attacked by a man". -On 05/19/21, staff interviews were conducted. -On 05/25/21, a care conference was held with Resident #1's family, PCP, the Ombudsman, RSD, Regional Director of Health (RDH), Activities Director (AD), and the Administrator. -The care conference completed on 05/25/21, was documented as, " discussed destructive behaviors, wandering in and out of other resident's rooms, undressing in their presence, urinating on people's floors and in their restrooms, and moving heavy furniture around the unit. -On 05/27/21, the RSD received notification from another resident's family member related to Resident #1 "went into another female resident's room in just a shirt and incontinence product", "got into bed" with the other resident, and was "rubbing her hands and arms". Telephone interview with Resident #1's PCP on 06/11/21 at 9:40am revealed: -Resident #1 was diagnosed with dementia of Alzheimer's type versus mixed dementia with moderate to severe degree of cognitive impairment, bilateral visual impairment, Benign Prostatic Hyperplasia (BPH), restless leg	D 276		

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D 276	Continued From page 23 syndrome hypertension and a pacemaker implantation. -Resident #1 was highly sensitive to medications in the form of increased falls and decreased blood pressure after taking medications. -In February 2021, Resident #1 was having multiple falls and drops in blood pressure related to his medications and several medications were discontinued. -Because of Resident #1's dementia he used non-pharmacological interventions which were appropriate for Resident #1. -The non-pharmacological interventions were interventions that worked well with Resident #1. -He was not informed the facility staff could not use the behavioral log due to Corporate instructions. -Every time he visited Resident #1 he would look at the behavioral logs and they were blank, incomplete or missing. -He informed the previous and current RSD they needed to be filled out as instructed in order for him to make appropriate recommendations. -Resident #1 had wandering behaviors, and was redirectable, calm, and non-aggressive. -His intent was to have the facility staff monitor for behaviors, follow his non-pharmacological interventions, document all behaviors and interventions as well as the successfulness of the interventions so that he would have all of the information available incase Resident's #1's behavior became unmanageable. -In the event Resident #1's behaviors became unmanageable with the interventions currently in place, then he would have to look at the risks versus benefits prescribing medications. -It was his understanding during the care plan meeting on 05/25/21 with the facility, the monitoring logs were not completed, and the goal was to manage the behaviors with	D 276		

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THE HAVEN IN THE VILLAGE AT CAROLINA PLACE	13150 DORMAN ROAD PINEVILLE, NC 28134

(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 276	Continued From page 24 non-pharmacological interventions, however the facility indicated they wanted medications prescribed, he disagreed. -Also, on 05/25/21, the care plan meeting was to discuss Resident #1's behaviors and the monitoring logs but the facility staff wanted Resident #1 admitted to a psychiatric hospital for treatment. -It was his expectation for the facility staff to supervise Resident #1 and complete the behavior log so that he might make a more informed decision without placing Resident #1 on medications which could cause more harm to Resident #1. -The facility did not complete the behavioral logs and he instructed the facility staff to continue to monitor Resident #1's behaviors and complete the behavior logs. Interview with the Licensed Practical Nurse (LPN) on 06/09/21 at 3:00pm revealed: -She was aware of the behavior logs for Resident #1. -She was told by the RSD to document all behaviors in the progress notes and fill out an incident report or document on the shift report forms every shift, every day. -She did not document on behaviors because she did not consider his behaviors abnormal. -She considered wandering normal for someone with his diagnosis and the redirection she provided was effective. Interview with a second LPN on 06/09/21 at 3:40pm revealed: -She worked for the facility a month now. -She was not aware of a behavioral log for Resident #1. -She was instructed by the other LPN to document increased behaviors on the shift report	D 276		

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D 276	Continued From page 25 sheet. -She had not documented any behaviors for Resident #1 on the shift reports. Interview with Resident #1's family member on 06/10/21 at 10:05am revealed: -The facility staff was given a list of non-pharmacological intervention that she and the physician developed based on what worked well with Resident #1. -Resident #1 wandered around in the facility and was easily redirected. -Resident #1 was highly sensitive to medications and developed reactions to the medications such as falls and decreased blood pressure which caused more falls. -Resident #1's PCP spoke with her in February 2021 and removed several medications from Resident #1's medication list and the decreased blood pressure and falls stopped. -Resident #1's PCP wanted to use non-pharmacological interventions with Resident #1. -The PCP wrote an order for the facility staff to keep a behavior log 24/7 of Resident #1. -The facility staff were to document the behavior, then document the non-pharmacological intervention(s) used and if the intervention was successful or not. -It was her understanding this was the way the PCP could determine after all non-pharmacological interventions were tried and failed then there would be a discussion about needing medications. -It was her understanding the current non-pharmacological interventions were successful with Resident #1 because the interventions were developed by her and the PCP based on what worked well for Resident #1. -On 05/25/21, there was an interdisciplinary team	D 276		

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D 276	Continued From page 26 (IDT) meeting at the facility, she, the Ombudsman and Resident #1's PCP attended. -The IDT meeting was arranged by the facility and included the Administrator, Nurse and some Corporate staff. -It was her understanding the IDT meeting was to discuss ways to help Resident #1 with what she thought were more non-pharmacological interventions but quickly turned into the facility reporting behaviors Resident #1 was having for months that she was not aware of. -She asked the Administrator and the Nurse about the behavior log and the non-pharmacological interventions and was told they were not doing them. -The facility Nurse had a few documents for the month of May 2021 behavioral logs, but she could not determine the behaviors or what they did for Resident #1. -The Administrator and facility Nurse led her to believe the behaviors Resident #1 had for months were "dangerous" but there was no documentation of them or informing her of them prior to 05/25/21. -It was her expectation the facility staff followed the PCP's order to keep a behavioral log, use and document the non-pharmacological interventions, and if those interventions did not work try another intervention and document all attempts. -If the interventions were used correctly and documented on the behavioral log the PCP could make further recommendations before jumping to medications that could harm Resident #1. Telephone interview with the Resident Care Coordinator (RCC) on 06/14/21 at 11:55am revealed: -She had been working as needed since January 2021 and was full time as of 06/15/21. -The PCAs were responsible for notifying the	D 276		

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D 276	Continued From page 27 MAs/LPN about Resident #1's behaviors and redirection. -The MAs/LPNs were responsible for documenting in the behavioral logs, shift reports and progress notes daily and per shift. -The RSD was responsible for reviewing the behavioral logs, shift reports and progress notes monthly for completion and for trends and patterns. Telephone interview with the RSD on 06/14/21 at 10:08 revealed: -She started working at the facility 03/15/21 as the RSD. -The facility did not have behavioral logs put in place by Resident #1's PCP in January and February 2021. -She and the Administrator communicated with the PCP about the behavioral logs not allowed in the facility but on 06/02/21 she spoke with the PCP related to the behavioral logs and was informed to continue with the behavioral logs for another 2 weeks and they would revisit the issue then. -She was trying to get the behavior logs discontinued since she started on 03/15/21 because the facility did not use those types of forms. -She was informed by the Administrator, in March 2021, the behavioral logs were not to be used. -The behavior log were not discontinued and were to be filled out until an alternate solution was in place. -The staff could document on the shift report sheets or in the progress notes. -As of 05/25/21, at the care plan meeting with Resident #1's family and PCP, the documentation was not completed as ordered. -It was the MAs responsibility to complete the behavioral logs, shift report, progress notes and	D 276		

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D 276	Continued From page 28 incident reports. -The previous RSD was responsible for monthly audits of the behavioral logs, shift reports, progress notes and incident reports prior to 03/15/21. -There were no monthly audits or Behavior Guidelines and Analysis reports completed by the previous RSD. -She was responsible for monthly audits of the behavioral logs, shift reports, progress notes and incident reports after 03/15/21. -She was also responsible for completing the Behavior Guidelines and Analysis report on Resident #1 which looked at incident reports, behavioral logs and reviewed for patterns and trends. -She was not able to complete the Behavior Guidelines and Analysis on Resident #1 until 05/26/21 after another family member reported Resident #1 was in her mother's room for 4-1/2 hours one night because until then she concentrated on training new staff. Interview with the Administrator on 06/14/21 at 2:53pm revealed: -She was aware the behavioral log was a physician's order but the behavioral log for Resident #1 was not supposed to be filled out because it was not in the facility's policy to do so. -The behavioral log was not a Corporate form. -She instructed the staff to document behaviors of increased wandering in the progress notes and shift reports. -Resident #1 had increased wandering behaviors and required cooperation from the PCP. -Resident #1 had a short attention span and she asked Resident #1's PCP for medications to stop the wandering behavior but the PCP refused. -Her job was to protect the other residents and she could not understand why medications could	D 276		

Division of Health Service Regulation

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D 276	Continued From page 29 not be ordered except for Resident #1's sensitivity to medications. -On 05/25/21, there was a meeting to discuss the fact they had tried all of the interventions for the behaviors and the interventions had failed. -There were inconsistent logs, shift reports, incident reports and progress notes and she instructed the staff to document on everything except the behavior logs. -The behavior logs did not have anything to do with the progress notes or the shift reports. -She expected the PCP to order medications to control the behaviors based on the RSD, and MAs giving a verbal report about the behaviors and not the behavior logs, regardless of the order because the behavior logs were not to be used per their Corporate instructions.	D 276
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: Based on observations, interviews, and record reviews, failed to respond to a reasonable request for one of one sampled resident related to a resident requesting a COVID 19 vaccine (Resident #2) and to permit a resident complaint without fear of retaliation (Resident #1). The findings are: 1. Review of Resident #1's current FL2 dated 07/21/20 revealed:	D 338

The Havens at Carolina Place – SOD Dated 7/6/2021

4) 10A NCAC 13F.0909 Resident Rights – "Based on observations, interviews, and record reviews, the facility failed to respond to a reasonable request for one of one sampled resident related to requesting a COVID vaccine (Resident #2) and to permit a resident complaint without fear of retaliation (Resident #1)."

A) The alleged deficient practice will be/ has been corrected for the listed residents by taking the following action:

Resident #1 was issued a discharge notice due to needing a higher level of care for supervision and behavior management, and has since been moved to another facility. Resident's behaviors were discussed in weekly at risk meetings.

The staff member accused of creating fear of retaliation is no longer with the company.

Resident #2 has started her vaccine regime. Multiple attempts were made at communicating with resident's POA to obtain consent for vaccination.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All residents have the potential to be affected.

All residents have been offered the COVID19 vaccine. All new admissions will be offered the COVID19 vaccine if needed.

All residents at risk for discharge/ in need of higher level of care are discussed weekly with the interdisciplinary team in risk meeting.

C) The following systemic changes will be made to ensure compliance with this regulation:

All staff will be in-serviced on Resident Rights no later than 8/18/21.

The community has spoken to all residents and family members and no other residents or family members were affected.

D) The facility will monitor the corrective action as follows:

Director of Resident Care/ designee will complete weekly audits for any residents who have not received the COVID19 vaccine and offering vaccine x 4 weeks.

This will be monitoring through monthly resident council meetings, and through the grievance process.

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D 338	Continued From page 30 -Diagnoses included dementia, anxiety hypertension, restless leg syndrome, lymphocytosis and glaucoma. -He was constantly disoriented and had wandering behaviors. -Resident #1 was ambulatory and the current level of care was documented as the special care unit (SCU). Review of Resident #1's discharge notice dated 06/02/21 revealed: -The reason for the discharge notice was the safety of the resident other individuals in this facility was endangered. -The planned discharge location had a name. -There was no documentation the facility had convened the adult care home resident discharge team. -The notice was signed by the Administrator and dated 06/02/21. Telephone interview with Resident #1's family member on 06/10/21 at 8:40am revealed: -On 04/21/21, Resident #1 had several bruises on his body noticed by the facility and her. -The facility did an investigation into the reason the bruises appeared. -After the investigation was over on 04/23/21 and it was determined the bruising was not caused from neglect, the Administrator informed her Resident #1 "got us in trouble and had to be discharged". -Resident #1 required increased supervision due to wandering tendencies. -Resident #1 was disoriented most of the time and that was nothing new for him. -Resident #1's Primary Care Physician (PCP) instructed the facility to document all of Resident #1's behaviors on a behavioral log and use the list of non-pharmacological interventions and	D 338		

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D 338	Continued From page 31 document how successful those interventions were. -This caused the facility to increase Resident #1's supervision because the facility staff needed to be thorough with the documentation so the PCP could get an idea of what was not working prior to ordering medication for Resident #1's. -Resident #1 was very sensitive to medications and caused falls and low blood pressures which caused Resident #1 to fall and get hurt. -On 05/27/21, she was informed Resident #1 was in another resident's room and caused harm to the other resident as well as to the other resident's belongings. -There were no other incidents reported to her related to destructive or harmful behaviors by Resident #1. -After the incident on 05/27/21, Resident #1 received a verbal discharge notice and was told she had to find a facility which would admit Resident #1. -She notified the Ombudsman and started calling facilities in the area for placement. -She received a mailed copy of the discharge notice along with the list of facilities on 06/06/21. -The facility staff had not called any of the facilities on the paper. -She contacted one facility and gave them the information about Resident #1 and was told they would start the process and do an evaluation of Resident #1. -She informed the Administrator about the facility wanting to do the evaluation and that facility was written on the discharge notice. -During the conversation on 05/28/21 with the Administrator, she was informed Resident #1 was being discharged because he had got them in trouble and was a danger to other residents. -The Administrator was not able to show her or provide her with any information related to	D 338		

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D 338	Continued From page 32 Resident #1 being a danger to any other residents. -On 05/25/21, during a care plan meeting the Administrator and Resident Service Director (RSD) informed her that because Resident #1's behaviors had increased, it put the other residents and risk and because the PCP would not order medications for Resident #1 to control the wandering behaviors, their legal department would be consulted about continuing care for Resident #1. Telephone interview with the Ombudsman on 06/11/21 at 11:32am revealed: -In February 2021, there was a complaint filed and the County Adult Home Specialist (AHS) was addressing the complaint. -On 04/21/21, she called the Administrator to set up a care plan meeting for Resident #1 and was told by the Administrator, Resident #1's family "got us in trouble for supervision" and another complaint was initiated over the bruises. -She tried to set up a care plan meeting and was refused by the Administrator because the Administrator was "going to discharge" Resident #1 "100%". -On 05/24/21, the Administrator informed her the complaint investigation into the bruises 04/21/21 was "cleared" by their Corporate office and the discharge would be coming. -On 05/25/21, there was to be a meeting with the facility staff, PCP, Resident #1's family and her to discuss Resident #1's behaviors and sleeping all day, instead it turned into the facility blaming the PCP for failing to prescribe medications to control Resident #1's behaviors with in 3 minutes. -The Administrator and the RSD wanted the PCP to order medications to control Resident #1's behaviors and refused so the Administrator wanted to discharge Resident #1 because of the	D 338		

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D 338	Continued From page 33 trouble Resident #1 was causing. -On 05/28/21, she received a call from Resident #1's family informing her Resident #1 was being discharged and she requested her assistance in finding Resident #1 a new facility. Interview with the Administrator on 06/10/21 at 10:30am revealed: -On 04/21/21 there was an investigation into Resident #1's bruises initiated by her because there were so many bruises and the family had concerns about how they appeared. -The facility was cited by the County for supervision of Resident #1. -She told the Ombudsman in April 2021, because of Resident #1's behaviors he was going to be discharged if they continued. -Resident #1 had increased behaviors in the past few months. -She had concerns because Resident #1's behaviors had increased and was considered dangerous to other residents. -She was not aware of any harm to other residents or staff from Resident #1. -There was no documentation of dangerous behaviors caused by Resident #1. -She considered Resident #1's wandering in and out of other resident's rooms and disassembling one resident's lamp as dangerous. -She issued a discharge notice on 06/02/21 because the safety of the residents or other individuals in the facility were endangered. -The family were responsible for finding placement for Resident #1. -She received a name of a facility from Resident #1's family and a date of 06/14/21 Resident #1 would be moving out. 2. Review of Resident #2's current FL2 dated 10/26/20 revealed: -Diagnoses included dementia, anxiety and	D 338		

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D 338	Continued From page 34 depression. -The recommended level of care was memory care or special care unit. -The resident was intermittently disoriented. Review of Resident #2's Guardianship papers revealed Resident #2 had a guardian. Interview with Resident #2 on 06/09/21 at 11:00am revealed: -The Administrator told her that they could not get in touch with her family member guardian, and they had to sign for the vaccine. -She tried to call her guardian, but he would not answer. -She had requested the COVID-19 vaccine sometime around February or March of 2021, but she was not sure of the specific time. -She felt like she needed the vaccine since everyone else was getting one. -"It may keep me from getting COVID". Telephone interview with the Primary Care Provider on 06/10/21 at 10:00am revealed: -The clinic did not need an order for the COVID-19 vaccine. -They were not administering the COVID-19 vaccine. -If the resident had a guardian the clinic may not administer without the guardians signature. -They had nothing to do with the COVID-19 vaccines. Interview with the Administrator on 06/10/21 at 2:30pm revealed: -She had been trying to contact Resident #2's guardian since mid-March 2021. -The guardian would not return the phone calls. -She had several different numbers and had left messages, but had not received a call.	D 338		

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D 338	Continued From page 35 -The clinic would not give the COVID-19 vaccine to anyone who had a guardian without the guardians consent. -She sent a certified letter to the guardian on 06/02/21. -There had not been a need to contact the guardian in the past, so she did not know there would be a problem contacting them. -There was a separate guardian for the residents financial needs. Attempted telephone interview with Resident #2's guardian on 06/10/21, 06/11/21 and 06/14/21 was unsuccessful.	D 338		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within on hour before or after the prescribed times for 4 of 6 sampled residents resulting in medications with multiple administration times being administered too close to the next scheduled administration times for 3 of 4 residents (Resident #4, #5, #6 and #7). The findings are:	D 364	The Havens at Carolina Place – SOD Dated 7/6/2021 5) 10A NCAC 13F.1004(g) Medication administration – "Based on observations, interviews, and record reviews, the facility failed to ensure medications within one hour before or after the prescribed times for 4 of 6 sampled residents resulting with medications with multiple administration times being administered too close to the next scheduled administration times for 3 of 4 residents (Resident #4, #5, #6, and #7)." A) The alleged deficient practice will be/ has been corrected for the listed residents by taking the following action: Morning medication pass times staggered by neighborhood with Nurse Practitioner approval. B) Other residents potentially affected by the same alleged deficient practice will be identified as follows: All residents have the potential to be affected. C) The following systemic changes will be made to ensure compliance with this regulation: All medication technicians not newly trained in the last 6 months attended a Medication Refresher course on 6/24/21. D) The facility will monitor the corrective action as follows: DRC/ designee to complete medication pass observations weekly x 4 weeks, then monthly x 4 months.	

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D 364	Continued From page 36 1. Observation of the medication pass on 06/09/21 between 9:00am and 10:00am revealed administration of Resident #4's morning medications at 9:13am included Miralax 17 grams, vitamin D3 25mcg, and Namenda 28 mg. Review of Resident #4's current FL2 dated 06/1/21 revealed: -Diagnoses included dementia, chronic atrial fibrillation, tachycardia and thrombocytopenia. -The medications listed on the FL2 included Miralax 17 grams once per day, Namenda XR 28 mg once per day, and vitamin D3 25mcg once per day, Review of the June 2021 Medication Administration Record (MAR) for Resident #4 revealed: -An entry for Namenda XR 28 mg once per day with no scheduled time for administration. -An entry for Miralax 17grams once per day with no scheduled time for administration. -An entry for vitamin D3 25mcg once per day with no scheduled time for administration. Refer to interview with the clinical director on 06/10/21 at 10:45am. Refer to interview with the Administrator on 06/14/21 at 12:45pm. Refer to interview with the Resident Care Director on 6/10/21 at 2:30pm. 2. Observation of the medication pass on 06/09/21 between 9:00am and 10:00am revealed administration of Resident #5's morning medications at 9:37am included Miralax 17 grams, vitamin D3 25mcg, and Tylenol 500mg.	D 364		

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D 364	Continued From page 37 Review of Resident #5's current FL2 dated 06/30/20 revealed diagnoses included dementia, and chronic obstructive pulmonary disease. Review of Resident #5's physician's order dated 03/21/21 revealed: -Vitamin D3 25mcg one tablet every day. -Miralax 17 grams every day. -Extra Strength Tylenol 500mg three times per day. Review of the June 2021 Medication Administration Record (MAR) for Resident #5 revealed: -An entry for Miralax 17grams once per day with no scheduled time for administration. -An entry for vitamin D3 25mcg once per day with no scheduled time for administration. -An entry for Extra Strength Tylenol 500mg three times per day with no scheduled time for administration. Refer to interview with the clinical director on 06/10/21 at 10:45am. Refer to interview with the Administrator on 06/14/21 at 12:45pm. Refer to interview with the Resident Care Director on 6/10/21 at 2:30pm. 3. Observation of the medication pass on 06/09/21 between 9:00am and 10:00am revealed administration of Resident #6's morning medications at 9:41am included Miralax 17 grams, vitamin D3 125mcg, Eliquis 5mg, Namenda 10mg, and Senexon-S 8.6/50mg. Review of Resident #6's current FL2 dated	D 364		

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D 364	Continued From page 38 01/15/21 revealed diagnoses included dementia, and acute bilateral pulmonary emboli. Review of Resident #6's physician's order dated 12/08/20 revealed: -Vitamin D3 125mcg one tablet every day. -Namenda 10mg one tablet twice per day. -Miralax 17 grams every day. -Eliquis 5mg one tablet twice daily. Senexon-S 8.6 - 50mg 1 tablet twice daily. Review of the June 2021 Medication Administration Record (MAR) for Resident # revealed: -An entry for Vitamin D3 125mcg one tablet every day no scheduled time for administration. -An entry for Namenda 10mg one tablet twice per day no scheduled time for administration. -An entry for Miralax 17 grams every day no scheduled time for administration. -An entry for Eliquis 5mg one tablet twice daily no scheduled time for administration. -An entry for Senexon-S 8.6 - 50mg 1 tablet twice daily no scheduled time for administration. Refer to interview with the clinical director on 06/10/21 at 10:45am. Refer to interview with the Administrator on 06/14/21 at 12:45pm. Refer to interview with the Resident Care Director on 6/10/21 at 2:30pm. 4. Observation of the medication pass on 06/09/21 between 9:00am and 10:00am revealed administration of Resident #7's morning medications at 9:45am included Lexapro 10mg, vitamin D3 25mcg, and Namenda 10mg.	D 364		

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D 364	Continued From page 39 Review of Resident #7's current FL2 dated 01/28/21 revealed diagnoses included dementia. Review of Resident #7's physician's order dated 03/02/21 revealed: -Namenda 10mg one tablet twice per day. -Vitamin D3 25mcg one tablet every day. -Lexapro 10mg one tablet every day. Review of the June 2021 Medication Administration Record (MAR) for Resident #7 revealed: -An entry for Lexapro 10mg one tablet every day no scheduled time for administration. -An entry for Vitamin D3 25mcg one tablet every day no scheduled time for administration. -An entry for Namenda 10mg one tablet twice per day no scheduled time for administration. Refer to interview with the clinical director on 06/10/21 at 10:45am. Refer to interview with the Administrator on 06/14/21 at 12:45pm. Refer to interview with the Resident Care Director on 6/10/21 at 2:30pm. --- Interview with the Licensed Practical Nurse (LPN) on 06/09/21 at 10:00am revealed: -She worked at the facility administering medications when they need her. -It took longer to administer the medications because she helped the residents with breakfast. -Some of the residents took longer to take their medications than others and some required more prompting. -Generally, the medications were done by 9:00am, but there were some residents that	D 364		

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D 364	Continued From page 40 required more attention this morning (06/09/21).. -She sometimes had to help with the daily care of the residents which slowed down her medication pass. Interview with the clinical director on 06/10/21 at 10:45am revealed: -There was not a written policy regarding medication administration times. -It was her expectation that all medications be administered as ordered and in the time frame which was one hour before or after scheduled unless otherwise specified . -Generally, the times are 8:00am, 12:00pm 4:00pm and 8:00pm, but those times could vary due to specific physician orders. -If the medications were going to be late the person administering the medications should notify the physician. -If the medications were ordered once per day there was more leeway in the administration times than if it was a twice or three times a day medicine. Interview with the Administrator on 06/14/21 at 12:45pm revealed: -The Resident Care Director (RCD) was responsible for overseeing the medications were being administered properly. -She knew sometimes there were emergencies and some of the residents required more care, so the medications may be administered a little later in those situations. -The administration times could vary between residents because of the type of medications and the activities in the building. Interview with the RCD on 6/10/21 at 2:30pm revealed: -She expected the medications to be	D 364		

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D 364	Continued From page 41 administered as ordered. -Unless specified by the physician the administration times were 8:00am, 12:00pm, sometimes 2:00pm and 4:00pm and 8:00pm. -She was not aware that the medications had been given late. -Sometimes it took longer with some residents than others. Telephone interview with the facility Primary Care provider on 6/14/21 at 11:15am revealed: -The facility usually did not notify them if medications were administered late. -If it was a once a day medication it was better to administer the medication late than to miss it altogether. -It was more important not to get multiple medications too close together. -A twice a day medication should have around 11 or 12 hours in between the administration times. -The facility assigned the administration times unless it was something that needed to be given at a specific time, then the order would specify a time.	D 364		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by:	D 378	The Havens at Carolina Place – SOD Dated 7/6/2021 6) 10A NCAC 13F.1006(b) Medication Storage – "Based on observations and interviews, the facility failed to ensure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration in a special care unit." A) The alleged deficient practice will be/ has been corrected for the listed residents by taking the following action: Medications found removed from resident's room immediately after facility notification. B) Other residents potentially affected by the same alleged deficient practice will be identified as follows: All residents have the potential to be affected. All resident rooms checked on 6/10/21 for hazardous materials. C) The following systemic changes will be made to ensure compliance with this regulation: All staff education on hazardous material that should not be in resident rooms in special care units. D) The facility will monitor the corrective action as follows: Director of Resident Care/ designee will complete hazardous materials audit weekly x 4 weeks, then monthly x 4 months.	

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D 378	Continued From page 42 Based on observations and interviews, the facility failed to ensure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration in a special care unit (SCU). The findings are: Review of Resident #3's current FL2 dated 06/07/21 revealed: -Diagnoses included Alzheimer's dementia. -The resident was disoriented intermittently. -The resident resided in a special care unit (SCU). Review of Resident #3's SCU resident profile and care plan dated 05/17/21 revealed: -Resident #3 required assistance for medication administration. -Resident #3 was to receive medications safely and as prescribed. a. Observation of Resident #3's room on 06/09/21 at 11:15am revealed: -There was a bottle of chlorhexidine 0.12% mouth wash. -There was a label on the bottle with a dispense date of 06/02/21, the resident's name, and the instructions to swish with 15ml for 30 seconds twice a day. Review of Resident #3's signed physician's orders dated 06/07/21 revealed there was no physician's order for chlorhexidine 0.12% mouth wash. Review of Resident #3's June 2021 electronic Medication Administration Record (eMAR) revealed: -There was no entry for chlorhexidine 0.12%	D 378		

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D 378	Continued From page 43 mouth wash. -There was no documentation the chlorhexidine 0.12% mouth wash had been administered. Interview with Resident #3 on 06/09/21 at 11:20am revealed: -He used the mouth wash when his mouth was sore. -He said he put the bottle to his mouth and drank it then swallowed. -He could not remember the last time her used the mouth wash. Telephone with Resident #3's responsible party on 06/09/21 at 12:30pm revealed: -Resident #3's dentist prescribed the mouth wash because his gums were sore after he had two teeth extracted on 06/02/21. -She intentionally put the mouth wash in his room because she did not trust the staff to make sure he would use it. -When she took Resident #3 to visit the dentist no one told her she was required to take any documents for the dentist to complete during the office visit. Telephone interview with the pharmacist at Resident #3's pharmacy on 06/11/21 at 10:15am revealed: -The chlorhexidine 0.12% was dispensed on 06/02/21. -Chlorhexidine was used to prevent infection of the gums and discomfort caused by inflammation in the mouth or throat. -If chlorhexidine was not used as directed it would not be effective. b. Observation of Resident #3's room on 06/09/21 at 11:15am revealed: -There was a bottle with 30 chewable tablets of	D 378		

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D 378	Continued From page 44 pepcid 10/800/165mg. -There was no label on the bottle with the resident's name and directions for the use of the pepcid. Review of Resident #3's signed physician's orders dated 06/07/21 revealed there was a physician's order for pepcid 10/800/165mg chewable tablets 1-2 tablets as needed for indigestion. Review of Resident #3's June 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for pepcid 10/800/165mg chewable tablets 1-2 tablets as needed for indigestion. -There was no documentation the pepcid was administered. Interview with Resident #3 on 06/09/21 at 11:20am revealed he did not know why he had the pepcid in his bathroom. Interview with a MA on 06/10/21 at 10:15am revealed: -She did not know Resident #3 had medications in his bathroom. -She administered Resident #3's medication locked in the medication cart. -Resident #3's medications were not supposed to be left in his room. -She did not look in the residents' bathroom cabinets unless she was using Resident #3's personal care items. Interview with the RCD on 06/10/21 at 8:15am revealed: -She expected the MAs and PCAs to lookout for medications left in the residents' rooms.	D 378		

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D 378	Continued From page 45 -The MAs were responsible for ensuring all medications were stored and locked in the medication carts. -She did not visit Resident #3's room daily. -She depended on staff entering Resident #3's room to remove medications found in his room. -When Resident #3 returned with his family from the dentist, staff failed to recover any physician notes and new medications Interview with the Administrator on 06/10/21 at 2:00pm revealed: -MAs were expected to make sure Resident #3's medications were kept locked up on the medication cart. -When residents went out for appointments and returned the person taking the resident to their appointment was supposed to take a physician visit and order form. -She depended on the RCD and MAs to make sure medications were kept on the medication cart.	D 378		
D 462	10A NCAC 13F .1305 Special Care Unit Policies And Procedures 10A NCAC 13F .1305 Special Care Unit Polices And Procedures The facility shall assure that special care unit policies and procedures are established, implemented by staff and available for review within the facility. In addition to all applicable policies and procedures for adult care homes, there shall be policies and procedures that address the following: (1) the philosophy of the special care unit which includes a statement of mission and objectives regarding the specific population to be served by	D 462		

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D 462	Continued From page 46 the unit which shall address, but not be limited to, the following: (a) safe, secure, familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medications; (b) a structured but flexible lifestyle through a well developed program of care which includes activities appropriate for each resident's abilities; (c) individualized care plans that stress the maintenance of residents' abilities and promote the highest possible level of physical and mental functioning; and (d) methods of behavior management which preserve dignity through design of the physical environment, physical exercise, social activity, appropriate medication administration, proper nutrition and health maintenance; (2) the process and criteria for admission to and discharge from the unit; (3) a description of the special care services offered in the unit; (4) resident assessment and care planning, including opportunity for family involvement in care planning, and the implementation of the care plan, including responding to changes in the resident's condition; (5) safety measures addressing dementia specific dangers such as wandering, ingestion, falls and aggressive behavior; (6) staffing in the unit; (7) staff training based on the special care needs of the residents; (8) physical environment and design features that address the needs of the residents; (9) activity plans based on personal preferences and needs of the residents; (10) opportunity for involvement of families in resident care and the availability of family support	D 462		

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D 462	Continued From page 47 programs; and (11) additional costs and fees for the special care provided. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure hazardous products were stored in a locked area resulting in a hazardous aerosol, and personal care items being unattended and accessible to residents who resided in the Special Care Unit (SCU). The findings are: Observation of residents' room during the initial tour of the facility on 06/09/21 from 9:10am to 10:15am revealed: -Room #205 was unlocked and easily assessible to the common living and dining room. -On the table at the entrance to room #205 sat an alcohol-based hand sanitizer containing 60% alcohol. -Over the bathroom sink in room #205, a razor, electrical tweezer, antibacterial soap, aftershave and shaving cream were sitting on the shelf. -In an unlocked cabinet on the wall over the toilet inside on the shelf there was an aerosol can with disinfectant spray and a bottle of moisturizing lotion. -In Room #203 there was a hairdryer lying on the sink plugged into an electrical outlet on the wall beside the sink. -Residents were observed in these rooms and walking past them in the common dining and living room. -Two residents were redirected out of residents' rooms that were not their rooms.	D 462		

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D 462	Continued From page 48 Observation of residents' room during the initial tour of the facility on 06/10/21 from 7:30am to 8:15am revealed: -Room #205 was unlocked and easily assessible to the common living and dining room. -On the table at the entrance to the resident's room in room #205 sat an alcohol-based hand sanitizer containing 60% alcohol. -Over the sink in the bathroom in room #205 a razor, electrical tweezer, antibacterial soap, aftershave and shaving cream were sitting on the shelf. -In the cabinet on the wall over the toilet inside on the shelf there was an aerosol can with disinfectant spray and a bottle of moisturizing lotion. -Residents were observed walking past room #205 in the common dining and living room. Telephone interview with the local poison control office on 06/11/21 at 8:45am revealed: -An aerosol disinfectant spray could cause a chemical burn to the skin, eyes, or any mucosal membrane of the body. -Ingestion of an alcohol-based hand sanitizer over a period could led to alcohol toxicity or altered mental status. -The shaving cream, aftershave, lotion, antibacterial soap could all cause nausea, vomiting, diarrhea, eye and gastrointestinal injury if ingested. -It was recommended that all these household items be kept out of reach of cognitively impaired people to prevent these injuries. -All of these household items were labeled with warning labels. Telephone interview a resident's family member on 06/10/21 at 5:00pm revealed: -She or another family member visited the	D 462		

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THE HAVEN IN THE VILLAGE AT CAROLINA PLACE	13150 DORMAN ROAD PINEVILLE, NC 28134

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D 462	Continued From page 49 resident every evening in the past ten weeks. -The resident's items in his room were purchased by the family and brought to him at the facility. -She was not informed these items could be a hazard to her family member or other residents. -The resident's cabinet in his bathroom had a child's safety lock on it that the resident would easily open to get to the items in the cabinet. -Sometimes the resident could not remember to lock the cabinet with the child safety lock and left it open. Interview with a personal care aide (PCA) on 06/09/21 at 9:30am revealed: -The residents' family members provided all the residents' personal items. -She was not aware the personal care items and disinfectant spray could harm any of the residents. -She removed the hair dryer from the resident's sink after she learned it remained there after personal care was provided this morning. Interview with a medication aide (MA) on 06/10/21 at 10:15am revealed: -She did not realize the items in the resident's rooms they used for personal care and disinfecting were a hazard to the residents. -She was not told to look for these items and report them left unsecured in the residents' rooms. Interview with a MA on 06/10/21 at 10:30am revealed: -She did not go into the residents' room to look for items that could harm the residents. -She did not routinely check residents' room for chemical hazards. Interview with a housekeeper on 06/10/21 at	D 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060163	A. BUILDING: _____ B. WING _____	C 06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 462	Continued From page 50 8:30am revealed: -She never looked at the personal items in residents' room. -She made sure all the cleaning items she used remained secured or watched them so no one would take them. Interview with the Resident Care Director (RCD) on 06/10/21 at 8:15am revealed: -She expected the MAs and PCAs to round and check on all residents every two hours during their shift. -If the MAs and PCAs identified any hazardous items in the residents' room they remove them or notify her about them. -She had not completed an educational training with the MAs and PCAs identifying hazardous items that should be locked up. -She walked through the facility daily but did not remove any hazardous personal items from residents' room. Interview with the Administrator on 06/10/21 at 2:00pm revealed: -She knew the protentional hazards related to the items left unsecured in the residents' rooms. -She expected the staff to recognize hazardous items in the residents' rooms. -She failed to provide any oversight to ensure the staff and the residents' families were aware the personal care items and disinfectant presented a potential hazard.	D 462		