STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Haven Health and Rehabilitation	620 Tom Hunter Road Charlotte, NC 28213

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, Medical Director and staff interviews, the facility failed to have documentation that the resident was informed in advance of the risks and benefits for the use of Chlordiazepoxide HCl (a psychotropic medication used to treat the symptoms of alcohol withdrawal) for 1 of 6 residents (Resident #88) reviewed for psychotropic medications. Findings included: Resident #88 was admitted to the facility on [DATE] and discharged on 5/18/25 with diagnoses which included anxiety, depression, and alcohol dependence with unspecified alcohol-induced disorder. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 was cognitively intact. A review of a Medical Director progress note dated 5/14/25 revealed Resident #88 was seen for alcohol use. The note indicated he left the facility to consume alcohol, which was against the protocol of the facility and Resident #88 agreed on 5/14/25 to be treated within the facility for his alcohol withdrawal symptoms. A review of Resident #88's physician's orders dated 5/14/25 revealed an order for Chlordiazepoxide HCl (Librium) to be given in a tapered dose over the course of five days. Day one (5/15/25) dose was two 25 milligram (mg) capsules to be given every six hours, day two dose (5/16/25) was two 25mg capsules every eight hours, day three dose (5/17/25) was two 25mg capsules every 12 hours, and day four and five dose on 5/18/25 and 5/19/25 was for two 25mg capsules one time a day for two days. A physician's order dated 5/14/25 to monitor resident every shift for signs and symptoms of alcohol withdrawal syndrome .tremors, shaking, anxiety, nausea, vomiting, headaches, elevated heart rate, sweating, irritability, confusion, insomnia, nightmares and high blood pressure. Notify MD if/when observed every shift for AWS (alcohol withdrawal symptoms). If aggression or violent behavior observed call 911. A review of Resident #88's EMR revealed consent forms for Buspirone (a medication used to treat anxiety) and Escitalopram (a medication used to treat major depressive disorder and generalized anxiety disorder) both dated 11/8/24 and signed by Resident #88. The EMR revealed no written consent form for Chlordiazepoxide HCl. A telephone interview with Resident #88 on 6/24/25 at 11:17 AM revealed Resident #88 stated he did not sign anything agreeing to the Chlordiazepoxide HCl and didn't recall agreeing to the treatment. A telephone interview with the Medical Director occurred on 7/3/25 at 3:02 PM. He stated he educated Resident #88 in person with Family Member #1 over the phone on all side effects of Chlordiazepoxide HCl. He discussed the possible side effects of Chlordiazepoxide HCl and the possible side effects of taking Chlordiazepoxide HCl and drinking alcohol. The Medical Director stated Resident #88 agreed to the treatment plan because of the severity of the situation and the consequences of bringing alcohol in the facility and endangering himself and others. An interview with the DON on 6/20/25 at 10:35 AM revealed she was a part of the conversation when Resident #88 was told about the medication plan. The DON stated she did not recall Resident #88 signing anything regarding the treatment plan. An interview with the Administrator on 6/20/25 at 11:22 AM revealed he set up a meeting with Resident #88, Family Member #1, and the Medical Director to discuss a treatment plan. The Administrator did not recall Resident #88 signing for the treatment. The Administrator stated the Medical Director put Resident #88 on Librium and it would help with his alcohol withdrawal symptoms. The Administrator stated the Medical Director suggested taking his privileges away to leave the building

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, resident, family member, and Medical Director interviews, the facility failed to allow a resident's choice regarding leave of absence (LOA) for 1 of 1 resident (Resident #88) reviewed for self-determination.Findings included:Resident #88 was admitted to the facility on [DATE] and discharged on 5/18/25 with diagnoses which included anxiety, depression, and alcohol dependence with unspecified alcohol-induced disorder. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 was cognitively intact and was not coded for any behaviors. Additionally, Resident #88's annual MDS assessment dated [DATE] revealed participating in his favorite activities and participating in outdoor activities were very important to him. A review of Resident #88's care plan last reviewed on 2/27/25, revealed he was non-compliant with the facility's rules on alcohol and management routinely confiscated alcohol from him. Interventions included not allowing Resident #88 to bring alcoholic beverages into the facility, encouraging peer bonds, and monitoring for symptoms of alcohol use. In addition, Resident #88's care plan indicated he had a history of alcohol and substance abuse, and staff reported the presence of alcohol intoxication and illegal substances at the facility. Interventions included educating Resident #88 on facility policies on consumption of alcohol, explaining the facility's responsibility for all resident's safety, and reporting any occurrences or suspicions to facility administration.A review of a nursing progress note written by Nurse #3 on 4/26/25 revealed, in part, Resident #88 was observed seated in the smoking courtyard and drinking a beer. Resident #88 was approached and made aware of the facility alcohol policy and that his room and backpack needed to be searched and he began to get agitated, and said, leave me alone. Resident #88 wheeled himself to his room and upon searching, nine cans of beer were taken from his backpack, and five empty cans from his bedside drawer. Resident #88 also had a strong smell of alcohol on his breath.A review of a nursing progress note written by Nurse #3 on 5/5/2025 revealed Resident #88 returned from LOA and a smell of alcohol was noticed. Resident #88 was made aware of the facility alcohol policy. His backpack was searched, and several cans of beer were taken away.A review of a Medical Director progress note dated 5/14/25 revealed Resident #88 was seen for alcohol use. The note indicated he left the facility to consume alcohol, which was against the protocol of the facility and Resident #88 agreed on 5/14/25 to be treated within the facility for his alcohol withdrawal symptoms. A review of Resident #88's physician's orders dated 5/14/25 revealed an order for chlordiazepoxide HCl to be given in a tapered dose over the course of five days. Day one (5/15/25) dose was two 25 milligram (mg) capsules to be given every six hours, day two dose (5/16/25) was two 25mg capsules every eight hours, day three dose (5/17/25) was two 25mg capsules every 12 hours, and day four and five dose on 5/18/25 and 5/19/25 was for two 25mg capsules one time a day for two days. A physician's order dated 5/14/25 to monitor resident every shift for signs and symptoms of alcohol withdrawal syndrome .tremors, shaking, anxiety, nausea, vomiting, headaches, elevated heart rate, sweating, irritability, confusion, insomnia, nightmares and high blood pressure. Notify MD if/when observed every shift for AWS (alcohol withdrawal symptoms). If aggression or violent behavior observed call 911.An additional review of Resident #88's physician's orders included an order written on 5/14/25 revoking Resident #88's LOA privileges due to poor safety awareness and risk of injury associated with ongoing behaviors due to alcohol dependency.A review of a social work progress note written on 5/14/25 by the SW revealed, in part, she spoke with Resident #88 and his family member regarding his alcohol use in the facility and when he left the facility. Resident #88 and his family member were made aware that this behavior would no longer be tolerated at the facility. He was informed that an order was written by the Medical Director that Resident #88 was no longer allowed to leave the facility due to excessive drinking and coming back intoxicated. The note further revealed that if Resident #88 left the facility it would be considered Against Medical Advice (AMA), and he would be discharged . Resident #88 and his family member understood.An interview with the Medical Director on 6/19/25 at 12:46 PM revealed that Resident #88 posed a threat to other residents and staff and was combative towards employees and other residents in the building. He stated Resident #88 was using alcohol in and out of the facility and it was decided he was no longer allowed to leave the facility on 5/14/25 during a meeting with Resident #88, Family Member #1 (over the phone), and the Director of Nursing (DON). A second telephone interview with the Medical Director occurred on 7/3/25 at 3:02 PM. He stated he educated Resident #88 in person with Family Member #1 over the phone on all side effects of Chlordiazepoxide HCl. He discussed the possible side

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, resident, family member, Medical Director and Adult Protective Services (APS) Social Worker (SW) interviews, the facility failed to provide a safe and orderly discharge for 1 of 3 residents reviewed for discharge (Resident #88). Resident #88 was being treated in the facility with Chlordiazepoxide HCl (a medication used to treat the symptoms of alcohol withdrawal also known as Librium) for a known history of alcohol abuse and received a dose a short time before exiting the facility on 5/18/25 at approximately 10:51 AM. The Medical Director wrote orders for Resident #88 to be monitored every shift for symptoms of alcohol withdrawal syndrome, such as tremors, shaking, anxiety, nausea, vomiting, headaches, elevated heart rate, sweating, irritability, confusion, insomnia, nightmares and high blood pressure the same day the Chlordiazepoxide HCl was initiated. Consuming alcohol while taking Chlordiazepoxide HCL could cause nausea and/or vomiting. When Resident #88 returned to the facility on 5/18/25 he begged staff to let him back in but, he was not allowed to re-enter the facility. There were no documented assessments of Resident #88 when he returned to the facility. Unit Manager #1 offered Resident #88 his belongings and medications to include the remaining Chlordiazepoxide HCL and Metoprolol (a medication used to lower blood pressure), which he refused except for his cigarettes. Resident #88 also refused to sign the Against Medical Advice (AMA) document. Unit Manager #1 failed to notify Emergency Medical Services (EMS) or have Resident #88 transferred to a higher level of care for ongoing monitoring when notified he had exited the facility or when he returned. Unit Manager #1 called law enforcement at 12:08 PM because staff wanted Resident #88 banned from the facility. Resident #88 did not have a planned discharge location, and no ongoing monitoring arranged. He was seen at the local convenience store, homeless, by staff members on 5/19/25 and 5/20/25 and no staff members offered assistance to Resident #88. In addition, Resident #88 was an amputee, mobile in a wheelchair, had no other source of money or resources, and did not have supplies for urinary incontinence. Resident #88 was found intoxicated by the APS SW at the convenience store on 5/20/25 and was taken to the hospital for chest pain and palpitations as well as left lower extremity pain due to a fall from his wheelchair. Resident #88 remailed homeless and a second hospitalization occurred on 5/29/25 and Resident #88 received intravenous antibiotics in the emergency department (ED) for left leg cellulitis (a bacterial infection involving the inner layers of the skin) and was discharged on 5/30/25 with a prescription for oral antibiotics. The third hospitalization was on 6/4/25 and Resident #88 presented with complaints of worsening left lower leg pain with erythema (redness) and edema (swelling) times one week. He was admitted to the hospital and treated with intravenous antibiotics for cellulitis for a wound on his left leg and monitored for alcohol withdrawal. Resident #88 declined placement in a skilled nursing facility and discharged AMA on 6/16/25 stating he was going to the street. Immediate jeopardy began on 5/18/25 when Resident #88 was not permitted to return to the facility after a brief leave of absence. Immediate jeopardy was removed on 6/27/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education. Findings included: Resident #88 was admitted to the facility on [DATE] with diagnoses which included hypokalemia, protein-calorie malnutrition, anxiety, depression, alcohol dependence with unspecified alcohol-induced disorder, and absence of right leg below the knee. Resident #88 and discharged on 5/18/25. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 was cognitively intact and was independent with Activities of Daily Living (ADLs) but needed supervision assistance with shower transfers. Resident #88 was not coded for any behaviors. The MDS further revealed he utilized a prosthetic limb for a below the knee amputation of his right leg and had occasional urinary incontinence. The MDS indicated he was not coded for any discharge planning to the community.A review of Resident #88's care plan last reviewed on 2/27/25 revealed he was non-compliant with the facility's rules on alcohol and management routinely confiscated alcohol from him. Interventions included not allowing Resident #88 to bring alcoholic beverages into the facility, encouraging peer bonds, and monitoring for symptoms of alcohol use. In addition, Resident #88's care plan indicated he had a history of alcohol and substance abuse, and staff reported the presence of alcohol intoxication and illegal substances at the facility. Interventions included educating Resident #88 on facility policies on consumption of alcohol, explaining the facility's responsibility for all resident's safety, and reporting any occurrences or suspicions to facility

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop an individualized person-centered comprehensive care plan in the areas of dialysis, Activity of Daily Living (ADL), insulin use, (Resident #23) for 1 of 20 residents reviewed for comprehensive care plans.The findings included:Resident #23 was admitted to the facility on [DATE] with diagnoses of end stage renal disease, encephalopathy, and diabetes. A review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #23 needed supervision to total assistance with ADL's. Resident #23 was also coded for insulin use, and dialysis. The MDS did not indicate Resident #23 exhibited any behaviors or rejection of care. The Care Area Assessment (CAA) on 4/14/25 indicated Resident #23 had a care area of ADL functional/rehab potential triggered. The CAA also indicated that Resident #23's ADL functional/rehab potential care area was addressed in the care plan.A review of Resident #23's electronic medical record (EMR) revealed a physician's order for dialysis three times a week. The EMR further revealed physician orders for Humalog injection solution (an insulin medication used to manage blood sugar levels), 100 unit/mg to be given subcutaneously before meals and at bedtime. A review of Resident #23's care plan as of 5/26/25 revealed there was no care area in place for insulin use, behaviors, dialysis, or ADL functioning.An interview with MDS Nurse #1 on 6/19/25 at 11:18 AM revealed staff nurses completed the initial, baseline care plan and then the MDS Nurses were responsible for completing the comprehensive care plan. MDS Nurse #1 stated former MDS Nurse #2 left the facility in May 2025 and Resident #23's comprehensive care plan was overlooked. MDS Nurse #1 stated she should have reviewed all new admissions to make sure all residents had a comprehensive care plan. An interview with the Director of Nursing (DON) on 6/20/25 at 10:28 AM revealed the comprehensive care plan was developed from the MDS and interdisciplinary team meetings, which occur weekly. She had the expectation Resident #23 would have a comprehensive care plan that addressed all his needs completed in the appropriate time frame.An interview with the Administrator on 6/20/25 at 11:19 AM revealed he had the expectation that Resident #23 would have a more thorough care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and physician interviews, the facility failed to transcribe an order of lorazepam gel (a medication used to treat anxiety) from the hospital discharge record to the electronic medical record (EMR) for Resident #23. Additionally, the failed to report a low heart rate of 46 (normal heart rate is 60 to 100 beats per min) to the medical provider prior to surveyor stopping Nurse #9 from administering Metoprolol (medication that lowers heart rate and blood pressure) to Resident #41. The facility also failed to follow an order to remove a lidocaine (topical pain medication) patch at bedtime for Resident #79. This was for 3 of 5 residents reviewed for professional standards of practice.The findings included: 1. A review of Resident #23’s hospital Discharge summary dated [DATE] listed lorazepam gel . 5mg/ml to be applied to the neck or wrist topically every 24 hours as needed. Resident #23 was admitted to the facility on [DATE] with diagnoses of end stage renal disease, depression, and diabetes. A review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #23 was cognitively intact. A review of a nursing progress note dated 4/30/25 read, in part, that Resident #23 was soiled and refused to allow staff to provide care. Three attempts at hygiene were made and Resident #23 started to swing his fists on both nurse and nurse aide, striking both staff members on the arm and hand while repeating No, no I'm going to wear this. I'm not taking this off. A review of a Psychiatric-Mental Health Nurse Practitioner (PMHNP) progress note dated 5/20/25 revealed, in part, Resident #23 was currently managed with lorazepam gel as needed for anxiety, which was well-tolerated without reported side effects. Plan to continue current lorazepam gel as needed regimen. Staff to maintain safety and provide supportive measures. Psychotherapy was recommended as an adjunct treatment. Staff to closely monitor mood and behaviors, given Resident #23’s history of non-compliance with medication. A review of an additional nursing progress note dated 6/16/25 revealed Resident #23 swung at Nurse Aide #1 with his fist and towel attempting to hit her. He was upset about her throwing away his blue bag. Writer attempted to calm Resident #23 and he refused his medications. A review of Resident #23’s Medication admission Record (MAR) from April, May, and June 2025 was completed. Lorazepam gel was not listed as a medication from 4/7/25 until 6/16/25. A review of an additional Psychiatric-Mental Health Nurse Practitioner (PMHNP) progress note dated 6/17/25 revealed a new order for fluoxetine (a medication used to treat depression) and a new order for lorazepam gel 0.5 milligram (mg)-1mg every 6 hours as needed for agitation/aggression was added. A review of Resident #88's electronic medical record (EMR) revealed a PMHNP order written on 6/17/25 for lorazepam gel 0.5mg-1mg every 6 hours as needed for agitation/aggression with a maximum dose of 3 milliliters (mL)/3 doses in 24 hours and to hold for sedation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the PMHNP on 6/19/25 at 10:28 AM revealed Resident #23 became agitated and physically aggressive when staff tried to clean or adjust anything in his room. The PMHNP indicated that in her note on 5/20/25, the reference to the lorazepam gel was from a previous order at Resident #23’s old facility. She stated the previous facility staff stated the lorazepam gel was effective for his anxiety. The PMHNP stated she was not aware Resident #23 ever had an order for the lorazepam gel at his current facility. An interview with the Medical Director on 6/19/25 at 12:41 PM revealed he was not aware of the lorazepam gel order when Resident #23 was admitted . He stated he would have wanted a discussion with the facility about the lorazepam gel. The Medical Director stated he would have probably referred to the PMHNP to see if the medication was appropriate for Resident #23. An interview with Nurse #4 on 6/19/25 at 3:37 PM revealed she did not recall admitting Resident #23 on 4/7/25 but stated when a new admission arrived at the facility, nursing had 24 hours to process the admission. She stated sometimes the task of adding the medications to EMR was delegated to the nurse by the unit manager. She did not recall an order for lorazepam gel for Resident #23. An interview with the Director of Nursing (DON) on 6/20/25 at 10:23 AM revealed Resident #23 had a history of combative behaviors but since he was admitted he was not combative but refused care. She stated the medications were put in the EMR by the admitting nurse and the discharge summary would be given to the provider and the provider could then decide to add or take away any medications or treatments. The DON had the expectation that the lorazepam gel would have been added to the MAR because it was a continued medication on the hospital discharge summary. She stated if there was a question about a medication listed, she had the expectation the admitting nurse would contact the provider for clarification. An interview with the Administrator on 6/20/25 at 11:13 AM revealed Resident #23 became agitated when he returned to the facility from his dialysis treatments and became upset when people were near his belongings. He stated the provider would have clarified any order when they completed their initial visit. The Administrator had the expectation that the admitting nurse should have processed the lorazepam gel and called the provider for clarification. 2.Resident #41 was admitted to the facility on [DATE] with diagnosis that included hypertension (high blood pressure) and cerebral infarction (brain tissue dies due to lack of oxygen supply to the brain). A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #41 was alert, disoriented to place, time, person, and event, speech was clear, and had a severe cognitive deficit. A review of the physician orders as of 6/18/25 revealed medication orders for: -Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 milligrams (MG) to give 1 tablet by mouth one time a day for hypertension dated 1/16/25. -Amlodipine Besylate Oral Tablet 10 MG, give 1 tablet by mouth one time a day for hypertension. Hold if systolic blood pressure is less than 110 dated 1/16/25 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 6/18/2025 at 8:43 AM revealed that Nurse #9 prepared morning medication that included Metoprolol 25 milligrams (mg) and Amlodipine 10 mg in two separate medication cups. She then stopped the Nurse Practitioner to ask if she should give the Amlodipine 10 mg if Resident #41’s heart rate was 46 beats per minute (bpm). The Nurse Practitioner stated, Amlodipine would be okay to administer. Nurse #9 placed the Amlodipine tablet in the medicine cup with the Metoprolol 25 mg and proceeded to give the medications to Resident #41. Surveyor stopped Nurse #9 and asked if she should give the Metoprolol with a heart rate of 46 beats per minute. Nurse #9 stated, she did not have parameters to hold Metoprolol. The Nurse Practitioner stated, “You do not have to have parameters to know to hold Metoprolol for heart rate less than 60 beats per min (bpm).” Nurse #9 stated she did not know you had to check for heart rate if there were no parameters written. The Nurse Practitioner manually checked Resident #41’s pulse by listening to his heart with her stethoscope. The Nurse Practitioner instructed Nurse #9 to hold the Metoprolol for the day and wrote an order to not give Resident #41 Metoprolol 25 mg if his heart rated was less than 60 bpm. An interview with the Medical Director was completed on 6/19/25 at 1:00 PM. The Medical Director stated that Resident #41 should have had parameters for the Metoprolol. The Medical Director stated that Nurse #9 should not give Metoprolol with a heart rate of 46 beats per minute until she had notified the provider. An interview with the Director of Nursing (DON) was completed on 6/20/25 at 10:49 AM. The DON stated she would have contacted the provider to hold the medication. The DON reported that if a nurse was unsure of medication, Nurse #9 could have checked in Point Click Care to check information regarding medication information. 3.Resident #79 was admitted to the facility on [DATE] with a diagnosis of left knee pain and left knee contracture. A review of Resident #79's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively intact. She had pain almost constantly. Her pain affected her sleep and interfered with her daily activities almost constantly. Resident #79 rated her pain as a 10 on a zero to 10 scale with zero being no pain and 10 being the greatest pain. Resident #79’s active physician's orders as of 6/19/25 revealed a physician's order dated 12/27/23 for a lidocaine (topical pain medication) 5 percent (%) patch to be applied topically to Resident #79's left knee in the morning for pain and remove at bedtime. An observation on 6/18/25 at 9:30 AM revealed Nurse #11 removed the lidocaine patch from Resident #79’s left knee prior to administering the lidocaine patch to Resident #79’s left knee as ordered. Nurse #11 stated that “someone must have forgot to take the patch off last night.” Resident #79's June 2025 Medication Administration Record (MAR) revealed documentation indicating Nurse #10 signed she had removed the lidocaine 5% patch from Resident #79’s left knee on 6/18/25 at 9:00 PM. (continued on next page)

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	345388	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Haven Health and Rehabilitation	620 Tom Hunter Road Charlotte, NC 28213

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The phone interview with Nurse #10 on 6/20/25 at 1:40 PM revealed that Nurse #10 could not remember if she had taken the lidocaine patch of Resident 79’s left knee. Nurse#10 stated she must have signed off the medication record and forgot to take the lidocaine medication patch off Resident #79’s left knee. An interview with the Medical Director was completed on 6/19/25 at 1:00 PM. The Medical Director stated that the lidocaine patch should not be on a resident longer than 12 hours because the absorption site would not be effective. Nurse #10 should have removed the patch at bedtime as ordered. An interview with the Director of Nursing (DON) was completed on 6/20/25 at 10:49 AM. The DON stated Nurse #10 should have followed the medication orders and removed the lidocaine patch form Resident #79’s left knee as ordered.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interview, the facility failed to implement the smoking policy for storage of smoking supplies (cigarettes/lighter) for 2 of 3 residents sampled for supervision to prevent accidents (Resident #85 and Resident #13). The findings included: A review of the facility's undated Smoking Agreement, undated Smoke Break Rules and undated Designated Smoking Times documents, indicated that smoking materials and incendiary devices (something that is capable of causing a fire or designed to start a fire) would at no time be stored in the residents' rooms. Smoking materials would be secured by the facility including lighters, cigarettes and e-cigarettes. The policy indicated that all residents who smoked would be evaluated for smoking safety upon admission, quarterly, at the time of a change in condition or if staff had a concern that re-evaluation was necessary. 1. Resident #85 was admitted to the facility on [DATE] with diagnoses which included nicotine dependence. A safe smoking assessment dated [DATE] revealed Resident #85 was a safe smoker, and the facility stored his smoking materials. A review of Resident #85's admission Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact and independent for most activities of daily living (ADLs). The MDS indicated Resident #85 ambulated independently in the facility. A review of Resident #85's care plan, revised on 04/10/25, revealed he was an unsupervised smoker. The goal was for Resident #85 to smoke independently through the next review date. Interventions included instructing the resident about smoking risk and hazards, instruct the resident about the facility policy on smoking. An observation was conducted of Resident #85 on 06/17/25 at 11:03 AM. Resident #85 was observed ambulating out of the facility door into the smoking area. He sat down in a chair, pulled out a lighter and one pack of cigarettes from his left side shirt pocket. Resident #85 was observed to smoke one cigarette and when he was finished he placed the smoking materials back into his left side shirt pocket and reentered the facility. An observation and interview was conducted of Resident #85 on 06/18/25 at 2:57 PM. Resident #85 was observed lying in bed with Nurse Aide (NA) #4 at bedside. NA #4 proceeded to pull out two packs of cigarettes and one lighter from the resident's bedside top dresser drawer to show the surveyor Resident #85 kept his smoking supplies at his bedside. Resident #85 stated he had always kept his smoking supplies in his room since admission and was aware of the smoking agreement/policy. He stated nobody had ever mentioned to him that he could not keep supplies in his room. An interview was conducted on 06/18/25 at 3:05 PM with NA #4. She stated she thought all residents in the facility were supposed to keep their smoking supplies in their assigned lockers located outside in the smoking area, however, when she asked Resident #85 about his smoking materials he stated to her he had the materials in his bedside dresser. NA #4 stated she was going to notify the nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/17/25 at 12:10 PM an interview was conducted with the facility Smoking Monitor #1. He stated he had been hired solely for monitoring the residents in the facility who smoked. The interview revealed his job was to ensure the safety of the residents while smoking and ensure he (Smoking Monitor #1) was outside during the smoking times. He stated the facility had a locker to keep residents' smoking materials in, each resident was assigned a locker, however, some of the residents were not keeping their materials in the assigned locker such as Resident #85. The interview revealed he (Smoking Monitor #1) had a difficult time with some of the residents keeping their smoking supplies when they went back in the building. He indicated the residents called him a snitch if he told them to put the supplies in their assigned locker so he had gotten to the point that he didn't want to say anything to them. He stated he had told the Administrator the residents were keeping their smoking supplies several weeks prior but to his knowledge it was ok that the residents were keeping their smoking supplies because the residents were independent smokers. On 06/19/25 at 2:38 PM an interview was conducted with Unit Manager #1. During the interview she stated residents smoking supplies were supposed to be kept in the residents' lockers. The facility tried to keep the smoking supplies locked up however families would bring in materials without their knowledge. She stated Resident #85 was an independent smoker and she wasn't aware of him having his smoking materials in the room. The interview revealed the facility had Smoking Monitor #1 that was supposed to watch the residents place their smoking supplies into their lockers and to let staff know if a resident was non-compliant. She stated she had not been notified that Resident #85 was non-compliant. On 06/19/25 at 9:07 AM an interview was conducted with the Director of Nursing (DON). During the interview she stated Resident #85 was non-compliant with keeping his cigarettes in the assigned locker and family members would bring in smoking materials without the facilities knowledge. The DON stated she felt like the Smoking Monitor #1 was helping with smoking compliance in the facility, but he needed to remind the residents to keep their smoking materials in their lockers. On 06/17/25 at 11:38 AM an interview was conducted with the Administrator. During the interview he stated he had multiple meetings with the residents about turning their smoking materials back in prior to re-entering the facility. He stated he had placed lockers in the smoking area and each resident had their own assigned key. The interview revealed he had attempted to confiscate materials, but the residents became upset. The facility had hired Smoking Monitor #1 to solely watch the residents during smoking times. He stated Resident #85 was non-compliant with the smoking policy, however it was a difficult situation because it would be hard to find him placement at another facility if they issued him a discharge notice for not following the smoking policy. Brown, Lynda2. Resident #13 was admitted to the facility on [DATE] with diagnoses which included incomplete paraplegia (partial paralysis of the lower body), chronic pain, orthostatic hypotension and generalized muscle weakness. Resident #13 was his own responsible party. He was in a private room and did not use oxygen. A smoking assessment dated [DATE] revealed Resident #13 was a safe smoker. A review of Resident #13's care plan revised on 5/7/2025 revealed he was a safe smoker. The goal was that Resident #13 would not suffer any injury from unsafe smoking practices through the review date. Interventions included observing Resident #13's clothing and skin for signs of cigarette burns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #13's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact and required maximum assistance with most Activities of Daily Living (ADL) and transfers from bed to wheelchair. The MDS indicated Resident #13 utilized a power wheelchair for mobility. On 6/17/2025 at 9:29 AM an interview with Resident #13 revealed he was a smoker. When asked what process he followed if he wished to smoke, he stated he asked staff to get him into his power wheelchair and he went to smoke. When asked if he stored his smoking materials and lighter with staff, he stated he handled that himself. When asked if he kept his smoking materials and lighter in his room, he stated he would not answer that question. An interview on 6/17/2025 at 10:02 AM with Nurse #3 indicated that Resident #13 generally kept his own smoking supplies (cigars and lighter) in his room. Nurse #3 stated Resident #13 was a safe smoker but did not comply with storing his smoking supplies in the lockers provided in the smoking area. An observation of Resident #13 on 6/17/2025 at 11:05 AM revealed approximately 12 cigars openly in view in a side pocket of the resident's backpack hanging on the back of his power wheelchair. Resident #13 was outside in the designated smoking area sitting in his power wheelchair next to a small table smoking a cigar in a safe manner. His lighter was on the table. An observation of Resident #13 on 6/18/2025 at 1:15 PM revealed the resident outside sitting in his power wheelchair near the front entrance while he waited on transportation. The cigars remained in open view in the side pocket of his backpack. He was not smoking at the time. On 6/17/2025 at 11:26 AM an interview with the Administrator revealed there were compliance issues with the smoking policy and the Administrator was working on these issues. He stated that the residents' family members brought in smoking materials, and it was difficult to monitor. The facility provided lockers for smoking materials, but most of the residents would not use the lockers. The facility hired Smoking Monitor #1 who had been working about 3 weeks. The Administrator stated he had called the Ombudsman for advice about the smoking issue and also held a Town Hall meeting that the Ombudsman attended to discuss the smoking policy with the residents. On 6/17/2025 at 12:14 PM an interview with Smoking Monitor #1 revealed that he worked 8:00 AM to 2:00 PM. He stated his job was to sit outside during the smoking times to monitor the residents. He stated the smoking times were 9:00 AM, 11:00 AM, 2:00 PM, 4:00 PM and 7:00 PM as unsupervised smoking was not permitted by the facility. He indicated he had tried get the residents to put their smoking materials and lighters in their lockers. He stated the residents were given a key to their individual locker and every day he asked the residents to use the lockers, but most became angry and just keep moving through the door back into the facility at the end of their smoke break. Smoking Monitor #1 estimated about 4 residents used the lockers. He stated he had been instructed not to confront Resident #13 about using his locker or relinquishing his smoking materials and lighter as Resident #13 would curse at staff. He stated Resident #13 kept his own cigars and lighter. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/2025 at 2:10 PM a telephone interview with the Ombudsman revealed that she had been in the building for another matter and had been invited to attend the Town Hall meeting. The Administration wanted to accommodate the residents who smoked as had recently received several new admissions from another facility and most were smokers. During the Town Hall meeting, not all of the residents who smoked were present. None of the residents had questions. The Administrator spoke with the Ombudsman twice over the phone requesting assistance with a new smoking plan as the old plan did not suit the new admissions. The Ombudsman stated she reviewed the residents' rights regarding smoking with the Administrator. She stated the facility's smoking policy would determine how the residents' smoking materials were managed. On 6/17/2025 at 2:15 PM an interview with Unit Manager #2 revealed Resident #13 kept his own smoking materials and lighter. She stated the facility tried to take his smoking materials in the past and store them with staff but was not successful as Resident #13 ordered more through delivery. She stated he was a safe smoker. On 6/18/2025 at 8:20 AM an interview with Nursing Aide #3 indicated Resident #13 basically did what he wanted to regarding smoking and kept his own smoking materials and lighter in his room. She stated he was a safe smoker. On 6/18/2025 at 9:20 AM an interview with Nurse #1 indicated Resident #13 kept his smoking materials and lighter in his room and did not comply with staff keeping his smoking materials in his locker in the smoking area. On 6/19/2025 at 3:15 PM an interview with the Social Worker indicated Resident #13 had a smoking assessment completed on admission and was found to be a safe smoker. He declined to sign a smoking agreement, and she stated there was not much she could have done about that. She indicated it was his right not to sign. The Social Worker stated she was aware he had his smoking supplies and lighter in his room. She stated Resident #13 ordered his smoking supplies and lighters through the mail and the facility could not search his packages. She indicated law enforcement had to be involved for the facility to search his room. She stated he stayed outside most of the day and had no incidents of smoking inside the facility. On 6/20/2025 at 10:57 AM an interview with the Director of Nursing (DON) indicated she was aware Resident #13 had his smoking materials and lighter in his room. She stated he ordered his own smoking materials and lighters and did not feel there was much the facility could do. He was non-compliant with almost everything and usually would not sign any documents including those related to smoking. On 6/20/2025 at 11:58 AM with the Administrator revealed he continued to work on the issues that existed around the residents smoking. Resident #13 was a challenging resident and had not complied with the smoking policy regarding turning his smoking materials and lighter over to staff.