STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086001	A. BUILDING: _____ B. WING _____	R 04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CARE	139 APEX LANE MOUNT AIRY, NC 27030

(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 and the Surry County Department of Social Services conducted an annual and follow-up survey on April 3, 2019 - April 4, 2019.	D 000	Filing the Plan of Correction does not constitute an admission that the deficiencies alleged, did, in fact, exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality resident care.	
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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure implementation of physician orders for 1 of 5 sampled residents (Resident #2) with physician's orders for Finger Stick Blood Sugar (FSBS) rechecks greater than 400. The findings are: Review of Resident #2's current FL2 dated 08/16/18 revealed: -Diagnoses included type II diabetes mellitus. -There was a physician's order for fingerstick blood sugars (FSBS) before meals and at	D 276	a) The RN consultant conducted an in-service on FSBS and insulin procedures with all medication aides. b) The RN consultant and/or designee will monitor through resident record reviews at least on a monthly basis to assure implementation of physician orders and treatments. c) The Administrator of the ACH and/or the RCC will conduct MAR audits weekly for one month, then once a month for three months and quarterly thereafter to assure correct documentation of Finger Stick Blood Sugars and correct administration and documentation of insulin.	04/10/2019 05/08/2019 and monthly thereafter Weekly 04/08/2019 thru 05/07/2019 Monthly 05/08/2019 thru 08/07/2019 quarterly thereafter

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Brandi Robertson — Administrator — 05/17/2019

reviewed and accepted 06/20/19 Jo Scarlett

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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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure implementation of physician orders for 1 of 5 sampled residents (Resident #2) with physician's orders for Finger Stick Blood Sugar (FSBS) rechecks greater than 400. The findings are: Review of Resident #2's current FL2 dated 08/16/18 revealed: -Diagnoses included type II diabetes mellitus. -There was a physician's order for fingerstick blood sugars (FSBS) before meals and at	D 276	a) The RN consultant conducted an in-service on FSBS and insulin procedures with all medication aides. b) The RN consultant and/or designee will monitor through resident record reviews at least on a monthly basis to assure implementation of physician orders and treatments. c) The Administrator of the ACH and/or the RCC will conduct MAR audits weekly for one month, then once a month for three months and quarterly thereafter to assure correct documentation of Finger Stick Blood Sugars and correct administration and documentation of insulin.	04/10/2019 05/08/2019 and monthly thereafter Weekly 04/08/2019 thru 05/07/2019 Monthly 05/08/2019 thru 08/07/2019 quarterly thereafter

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D 276	Continued From page 1	D 276		

bedtime.
-There was a physician's order for Novolog (fast-acting insulin to lower blood sugar) insulin sliding scale with parameters to inject 12 units of Novolog for FSBS greater than 400 and to recheck in one hour. If FSBS remains above 400 give 10 units of Novolog.

Review of Resident #2's physician's order dated 09/21/18 revealed an order to check and record FSBS three times a day before meals and inject Novolog insulin based on sliding scale parameters. For FSBS greater than 400 give 14 units, and recheck within two hours. If still greater than 400 give 12 units.

Review of Resident #2's physician's order dated 03/04/19 revealed an order to check and record FSBS three times a day before meals and inject Novolog insulin based on sliding scale parameters. For FSBS greater than 400 give 14 units, and recheck within two hours. If still greater than 400 give 12 units.

Review of Resident #2's February 2019 Medication Administration Record (MAR) revealed:
-There was an entry for FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm.
-There was a second entry for Novolog sliding scale insulin three times a day before meals scheduled at 6:30am, 11:30am, and 4:30pm with sliding scale parameters for FSBS greater than 400 give 14 units, and recheck within two hours. If still greater than 400 give 12 units.
-There were thirteen FSBS documented greater than 400 and should have been rechecked two hours later.
-There was documentation one of the thirteen

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D 276	Continued From page 2 FSBS was rechecked between 02/01/19 through 02/28/19. -The FSBS greater than 400 that required a recheck and possible additional insulin were documented as follows: -On 02/02/19 at 6:30am FSBS was 421. -On 02/10/19 at 11:30am FSBS was 408. -On 02/11/19 at 6:30am FSBS was 472. -On 02/13/19 at 4:30pm FSBS was 426. -On 02/16/19 at 6:30am FSBS was 513. -On 02/16/19 at 4:30pm FSBS was 491. -On 02/17/19 at 6:30am FSBS was 423. -On 02/18/19 at 4:30pm FSBS was 423. -On 02/19/19 at 6:30am FSBS was 406. -On 02/21/19 at 11:30am FSBS was 458. -On 02/23/19 at 6:30am FSBS was 453. -On 02/23/19 at 11:30am FSBS was "Hi" (greater than 550 or 600). -On 02/23/19 at 4:30pm FSBS was 452. Review of Resident #2's March 2019 MAR revealed: -There was an entry for FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm. -There was a second entry for Novolog sliding scale insulin three times a day before meals scheduled at 6:30am, 11:30am, and 4:30pm with sliding scale parameters for FSBS greater than 400 give 14 units, and recheck within two hours. If still greater than 400 give 12 units. -There were sixteen FSBS greater than 400 and should have been re-checked within two hours. -There was no documentation any of the sixteen FSBS were rechecked between 03/01/19 through 03/31/19. -The FSBS greater than 400 that required a recheck and possible additional insulin were documented as follows: -On 03/03/19 at 6:30am FSBS 429.	D 276		

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D 276	Continued From page 3 -On 03/04/19 at 6:30am FSBS 503. -On 03/04/19 at 11:30am FSBS 408. -On 03/09/19 at 4:30pm FSBS418. -On 03/18/19 at 4:30pm FSBS502. -On 03/20/19 at 6:30am FSBS424. -On 03/21/19 at 6:30am FSBS419. -On 03/21/19 at 11:30am FSBS 401. -On 03/21/19 at 4:30pm FSBS403. -On 03/22/19 at 6:30am FSBS462. -On 03/22/19 at 11:30am FSBS 430. -On 03/25/19 at 11:30am FSBS 414. -On 03/26/19 at 6:30am FSBS418. -On 03/26/19 at 4:30pm FSBS406. -On 03/27/19 at 6:30am FSBS404. -On 03/29/19 at 4:30pm FSBS404. Review of Resident #2's April 2019 MAR revealed: -There was an entry for FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm. -There was a second entry for Novolog sliding scale insulin three times a day before meals scheduled at 6:30am, 11:30am, and 4:30pm with sliding scale parameters for FSBS greater than 400 give 14 units, and recheck within two hours. If still greater than 400 give 12 units. -There were three FSBS greater than 400 and should have been rechecked within two hours. -There was no documentation any of the three FSBS were rechecked between 04/01/19 through 04/03/19. -The FSBS greater than 400 that required a recheck and possible additional insulin as follows: -On 04/01/19 at 11:30am FSBS was 438. -On 04/02/19 at 11:30am FSBS was 412. -On 04/03/19 at 11:30am FSBS was 411. Interview with Resident #2 on 04/04/19 at 3:41pm revealed:	D 276		

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D 276	Continued From page 4 -He had resided at the facility since July 2018. -He was a diabetic and facility staff checked his blood sugar four times a day. -His blood sugar was often "Hi" being greater than 500 or 600, he was not sure. -He did not know when his blood sugar was high because he felt the same as usual. -He did not recall staff checking his blood sugar more than four times a day. -Staff did not tell him if they needed to recheck his blood sugar. Interview with the Resident Care Coordinator on 04/04/19 at 11:40am revealed: -There were orders to recheck Resident #2's FSBS when results were greater than 400. -The medication aides (MAs) should recheck the resident's FSBS and document the results. -If the MAs administered additional insulin, the MAs should document on the MAR the units of insulin administered. -A "HI" (high) reading on the glucometer she believed was FSBS that were greater than 550 or 600, because the glucometer displayed FSBS reading that were in the low 500's. Interview with a first shift MA on 04/04/19 at 11:30am revealed: -He did not recall rechecking Resident #2's FSBS when results were greater than 400. -If he had rechecked the resident's FSBS he would document the recheck results on the MAR or on the facility's FSBS reading sheets. -If there was no documentation he did not recheck the resident's FSBS. Interview with a second shift MA on 04/04/19 at 5:51pm revealed: -She knew that Resident #2 had orders to recheck FSBS when results were greater than	D 276		

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D 276	Continued From page 5 400. -She would have documented the recheck on the MAR or FSBS reading sheet. -She did not remember rechecking Resident #2's FSBS. Interview with the Administrator on 04/04/19 at 4:01pm revealed: -The MAs were responsible for checking Resident #2's FSBS. -If the resident had an order to recheck his FSBS, she expected the MAs to recheck the resident's FSBS. -The MAs should document the recheck of the FSBS reading on the MAR or on the facility's FSBS reading sheet. Interview with Resident #2's primary care physician on 04/04/19 at 12:23pm revealed: -Resident #2 always had blood sugars that were over 400. -He ordered a fast-acting insulin to be administered according to a sliding scale. -He expected facility staff to recheck Resident #2's FSBS when the first FSBS was greater than 401 or greater. -If the second FSBS was greater than 400then insulin should be administered according to the order and rechecked again. -If facility staff were unable to recheck the resident's FSBS and administer the insulin as ordered then facility staff should have contacted him.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes:	D 310		

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D 310	Continued From page 6 (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 sampled residents (Resident #4) with diet orders for a pureed diet. The findings are: Review of Resident #4's current FL2 dated 03/05/19 revealed: -Diagnoses included dementia, pneumonia, atrial fibrillation, and cardiomyopathy. -There was an order for a dysphagia pureed diet. Review of Resident #4's hospital discharge summary dated 03/16/19 revealed: -Resident #4 was admitted to the hospital for pneumonia. -The resident had a speech evaluation and was found to have dysphagia. -Resident #4 was ordered a pureed diet. Review of Resident #4's nurse notes on 04/02/19 at 1:00pm revealed staff documented the resident was on a pureed diet due to aspiration pneumonia.	D 310	a) The RN consultant, or designee, will in-service the dietary personnel on therapeutic menus, with emphasis on puree diets as ordered by the resident's physician. b) The Administrator, or designee, will monitor one meal once a week for one month, then monthly for three months and quarterly thereafter.	05/08/2019 Weekly 05/09/2019 thru 05/31/2019 monthly 06/01/2019 to 09/01/2019 quarterly thereafter

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D 310	Continued From page 7 Review of the therapeutic diet list posted in the kitchen dated 02/11/19 revealed Resident #4 was to be served a pureed diet. Review of the facility's therapeutic diet menu for the lunch meal for Wednesday, 04/03/19revealed residents ordered a pureed diet were to be served pureed Italian wedding soup, no crackers, pureed egg salad sandwich, pureed pasta salad, pureed melon cubes, milk and beverage of choice. Observation of the lunch meal service on 04/03/19 from 12:00pm to 1:00pm revealed: -The dietary manager (DM) and the cook served the meal. -Resident #4 was served vegetable soup with chunks of vegetables, whole cheese sandwich, three inch by two and one-half inch square of strawberry cake, milk and water. -The resident consumed 50% of the meal without difficulty. Review of the facility's therapeutic diet menu for the dinner meal for Wednesday, 04/03/19 revealed residents ordered a pureed diet were to be served pureed Salisbury steak, mashed potatoes, pureed green peas, pureed wheat roll, pureed peach pie, milk and beverage of choice. Observation of the dinner meal service on 04/03/19 at 5:15pm revealed: -The dietary aide served Resident #4 whole fruit cocktail, whole biscuit, whole chicken breast, whole broccoli with cheese, whole black-eyed peas, a whole biscuit, water and tea. -At 5:20pm the Resident Care Coordinator (RCC) was informed the resident's meal served was not pureed. -The RCC told the DM and she took Resident	D 310		

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D 310	Continued From page 8 #4's food to the kitchen. Observation of Resident #4's dinner meal served by the DM on 04/03/19 from 5:31pm to 6:20pm revealed: -The fruit cocktail had chunks of fruit, the black-eyed peas had whole and half pieces of peas, the chicken was creamy and the broccoli had small pieces identifiable as broccoli, and a whole biscuit. -The resident consumed 10% of the meal without difficulty. Based on observation, interview and record review it was determined Resident #4 was not interviewable. Interview with the DM on 04/03/19 at 5:43pm revealed: -She knew Resident #4 was ordered a pureed diet. -She thought Resident #4 was served a pureed meal; she must have mixed the meals up. -The RCC informed her that Resident #4's meal was not pureed. -She took the meal from the resident and went to the kitchen puree the food on Resident #4's plate. -She tried to puree the meal quickly so the resident did not have to wait a long time to finish his meal. -She was responsible for pureeing food and ensuring the texture of the food was as ordered. -She did not know what to do with the biscuit so she gave the biscuit to the resident whole. Interview with the dietary aide on 04/03/19 at 5:56pm revealed: -He forgot Resident #4 was ordered a pureed diet because the resident had been in the hospital recently and had not been present for meals.	D 310		

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D 310	Continued From page 9 -He did not check the diet list when preparing Resident #4's meal. Interview with the RCC on 04/03/19 at 6:10pm revealed: -She sometimes observed meals in the dining room, but did not specifically observe and check to ensure diets were served as ordered. -She knew the kitchen staff had been made aware Resident #4 was ordered a pureed diet because she updated the diet list and posted it in the kitchen for dietary staff to view when preparing meals. Interview with the Administrator on 04/03/19 at 6:45pm revealed: -She did not know why there was confusion regarding Resident #4's diet because she specifically discussed Resident #4's pureed diet with all dietary staff including the DM. -No staff had been assigned to observe meals , but she was going to have another discussion with dietary staff regarding serving diets as ordered.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.	D 344	a) The Administrator will in-service supervisory staff on the need to verify and clarify orders for medications and treatments if orders are not clear, complete or if multiple orders are received but are not the same. b) The RN consultant and/or designee will monitor through resident record reviews at least on a monthly basis to assure implementation of physician orders and treatments and to assure the physician has been contacted regarding any needed clarification of orders. Continued	04/05/2019 and 05/14/2019 05/08/2019 and monthly thereafter

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D 344	Continued From page 10 The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews the facility failed to contact the physician to clarify medication orders for 2 of 5 sampled residents (Residents #1 and #2) regarding sliding scale insulin (#1 and #2), and an antihypertensive and neuropathy medications (#1). The findings are: 1. Review of Resident #2's current FL2 dated 08/16/18 revealed: -Diagnoses included type II diabetes mellitus. -There was a physician's order for fingerstick blood sugars (FSBS) before meals and at bedtime. -There was a physician's order for Novolog sliding scale insulin (SSI) (a rapid-acting insulin used to lower elevated blood sugar levels) with parameters to inject insulin for FSBS 150-200= 4 units, 201-250= 5 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, greater than 400= 12 units and recheck in one hour. If FSBS remains above 400 give 10 units of Novolog. Review of Resident #2's subsequent physician's order dated 09/21/18 revealed an order to check and record FSBS three times a day before meals and inject Novolog insulin based on sliding scale	D 344	c) The RN consultant and/or designee will monitor through resident record reviews at least on a monthly basis to assure correct administration and documentation of insulin and all other medications.	05/08/2019 and monthly thereafter

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D 344	Continued From page 11	D 344		

parameters of 150-200= 6 units, 201-250= 7 units, 251-300= 8 units, 301-350= 10 units, 351-400= 12 units, greater than 400= 14 units, and recheck within two hours. If still greater than 400 give 12 units.

Review of Resident #2's subsequent physician's order dated 03/04/19 revealed an order to check and record FSBS three times a day before meals and inject Novolog insulin based on sliding scale parameters of 150-200= 6 units, 201-250= 7 units, 251-300= 8 units, 301-350= 10 units, 351-400= 12 units, greater than 400= 14 units, and recheck within two hours. If still greater than 400 give 12 units.

Review of Resident #2's February 2019 Medication Administration Record (MAR) revealed:
-An entry for FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm.
-An entry for Novolog sliding scale insulin three times daily at 6:30am, 11:30am, and 4:30pm.
-There was no entry for Novolog sliding scale insulin at 8:00pm.

Review of Resident #2's March 2019 MAR revealed:
-An entry for FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm.
-An entry for Novolog sliding scale insulin three times daily at 6:30am, 11:30am, and 4:30pm.
-There was no entry for Novolog sliding scale insulin at 8:00pm.

Review of Resident #2's April 2019 MAR revealed:
-An entry for FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm.
-An entry for Novolog sliding scale insulin three

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times daily at 6:30am, 11:30am, and 4:30pm.
-There was no entry for Novolog sliding scale insulin at 8:00pm.

Review of Resident #2's record revealed there was no documentation the physician had been contacted regarding the 8:00pm FSBS greater than 150 with no insulin coverage.

Interview with Resident #2 on 04/04/19 at 3:41pm revealed:
-He was a diabetic and facility staff checked his FSBS before meals and at bedtime.
-He was administered a fast acting insulin when his FSBS were a certain number.
-He probably needed the fast-acting insulin at bedtime because his blood sugars were always greater than 200, more like 300 and 400.
-He had not seen the physician for several months and did not know the orders for his insulin coverage.

Interview with the Resident Care Coordinator on 04/04/19 at 11:40am revealed:
-Most days she worked as the first shift MA.
-She usually checked Resident #2's FSBS and administered Novolog SSI for FSBS greater than 150.
-The sliding scale order did not cover the bedtime FSBS therefore no insulin was administered.

Interview with a MA on 04/04/19 at 5:51pm revealed:
-She checked Resident #2's FSBS before bedtime.
-Resident #2 had a sliding scale that was administered with meals only.
-Most of the time Resident #2's FSBS ranged 200 or greater.
-She had not contacted Resident #2's physician

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D 344	Continued From page 13 regarding bedtime coverage of the FSBS because she did not think it was problem. Interview with the Administrator on 04/04/19 at 4:01pm revealed: -If the MAs were not sure of an order they should contact the physician to clarify the order. -The facility currently did not have a system of comparing orders to MARs and following-up with the physician. Interview with Resident #2's primary care physician on 04/04/19 at 12:23pm revealed: -In September 2018, he reviewed Resident #2's FSBS results and noticed they were elevated and he increased Novolog SSI. -He still expected the resident's FSBS to be checked four times daily and SSI to be administered. -The facility staff should have called to clarity the order because the resident had no fast-acting insulin for elevated blood sugars at bedtime and Resident #2's blood sugars were always elevated. -The facility staff always gave him paperwork to sign, and he did not realize Resident #2's medication order for Novolog SSI was changed to three times daily. 2. Review of Resident #1's current FL2 dated 03/25/19 revealed diagnoses included diabetes mellitus, acute respiratory failure with hypoxia, muscle weakness, chronic kidney disease(stage 3), chronic obstructive pulmonary disorder with exacerbation, pneumonia, and chronic pain. a. Review of Resident #1's current FL2 dated 03/25/19 revealed: -There was a physician's order for fingerstick blood sugar (FSBS) before meals scheduled for 6:00 am, 11:30 am, 4:30 pm, and at night	D 344		

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D 344	Continued From page 14 scheduled for 8:00 pm. -There was a physician's order for Novolog sliding scale insulin (SSI) (a rapid-acting insulin used to lower elevated blood sugar levels) before meals with parameters to inject insulin for FSBS =150-200, administer 4 units; 201-250, administer 6 units; 251-300, administer 8 units; 301-350, administer 10 units; 351-400, administer 12 units; 401 or greater, administer 14 units; recheck in one hour; if still greater than 400, give 10 additional units. Review of Resident #1's physician's order dated 09/17/18 revealed Novolog SSI inject before meals with parameters as follows: -FSBS to be checked before each meal and at bedtime. -If fingerstick blood sugar (FSBS) was 150-200, administer 4 units of SSI. -If FSBS was 200-250, administer 6 units of SSI. -If FSBS was 251-300, administer 8 units of SSI. -If FSBS was 301-350, administer 10 units of SSI. -If FSBS was 350-400, administer 12 units of SSI. -If FSBS was 401 or greater, administer 14 units of Novolog SSI and recheck FSBS in one hour. -If FSBS was still 401 or greater, administer 10 units of SSI. Review of Resident #1's physician's order dated 02/25/19 revealed an order to increase Levamir (a long-acting insulin used to lower elevated blood sugar levels) from 65 units at night to 70 units at night. Review of Resident #1's physician's orders dated 02/26/19 and 03/04/19 revealed a Novolog SSI before meals with parameters as follows: -FSBS to be checked before each meal and at bedtime. -If FSBS was 150-200, administer 6 units of SSI.	D 344		

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D 344	Continued From page 15 -If FSBS was 201-250, administer 8 units of SSI. -If FSBS was 251-300, administer 10 units of SSI. -If FSBS was 301-350, administer 12 units of SSI. -If FSBS was 351-400, administer 14 units of SSI. -If FSBS was greater than 400, administer 16 units of SSI. -If FSBS was still greater than 400, recheck FSBS in two hours, and if it remained greater than 400, administer 10 units of SSI. Review of Resident #1's February 2019 medication administration record (MAR) revealed: -There was an entry for FSBS to be checked and recorded four times a day scheduled at 6:00 am, 11:30 am, 4:30 pm, and 8:00 pm. -There was an entry for Novolog SSI to be administered when checking and recording FSBS before meals at 6:00 am, 11:30 am, and 4:30 pm. -There was an entry for SSI parameters as follows: 150-200 =4 units, 201-250=6 units, 250-300 =6 units, 301-350 =10 units, 351-400 =12 units, 401 or greater =14 units and recheck in one hour, if FSBS remained at 400 or greater, give 10 units. - There was a second entry dated 02/26/19 for SSI with parameters as follows: 150-200 =6 units, 201-250 =8 units, 251-300 =10 units, 301-350 =12 units, 351-400 =14 units, and if FSBS remained greater than 400 =16 units. -FSBS ranged from 220 to 554 from 02/01/19 to 02/28/19. Review of Resident #1's March 2019 MAR revealed: -There was an entry for FSBS to be checked and recorded four times a day scheduled at 6:00 am, 11:30 am, 4:30 pm, and 8:00 pm. -There was an entry for Novolog SSI to be given when checking and recording FSBS before meals at 6:00 am, 11:30 am, and 4:30 pm.	D 344		

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D 344	Continued From page 16 - There was an entry for SSI with parameters as follows: 150-200 =4 units, 201-250 =6 units, 251-300 =8 units, 301-350 =10 units, 351-400 =12 units, and if FSBS remained greater than 400 =10 units. -FSBS ranged from 178 to 445 from 03/01/19 to 03/31/19. Review of Resident #1's April 2019 MAR revealed: -There was an entry for FSBS to be checked and recorded four times a day scheduled at 6:00 am, 11:30 am, 4:30 pm, and 8:00 pm. -There was an entry for Novolog SSI to be given when checking and recording FSBS before meals at 6:00 am, 11:30 am, and 4:30 pm. - There was an entry for SSI with parameters as follows: 150-200 =4 units, 201-250 =6 units, 251-300 =8 units, 301-350 =10 units, 351-400 =12 units, and if FSBS remained greater than 400 =10 units. -FSBS ranged from 189 to 456 from 04/01/19 to 04/04/19. Interview with Resident #1 on 04/03/19 at 10:00 am revealed: -He was diabetic and facility staff checked his FSBS before meals and at night. -Staff checked his FSBS before meals and gave insulin based on his blood sugar readings. -Staff checked his FSBS at night, but there was no insulin given based on blood sugar readings. -The physician had seen his blood sugar readings and had increased his long acting insulin "about one month ago". -He did not know what the orders were for the sliding scale insulin. Interview with the Resident Care Coordinator (RCC) on 04/04/19 at 4:10 pm revealed:	D 344		

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D 344	Continued From page 17 -She usually worked as the first shift medication aide (MA), but she would sometimes be there for second shift as well. -Resident #1 had scheduled insulin at 7:00 pm, but no SSI was ordered for the 8:00 pm FSBS check. -MA's were supposed to give the SSI based on the FSBS reading before meals. -She had not considered clarifying how many times to recheck Resident # 1's blood sugar if it continued to be over 400 after the additional units of SSI were given. Telephone interview with Resident #1's primary care physician (PCP) on 04/04/19 at 6:46 pm revealed: -He did not know how the order was worded for FSBS and SSI administration. -If FSBS were ordered four times a day, the order for SSI would normally apply to each time the FSBS was done. -The resident was administered a long-acting insulin each evening and the expectation would be for staff to have contacted the PCP for the 8:00 pm FSBS results of 400 or greater for instructions to administer SSI at that time. -The staff should have called to clarify the order because Resident # 1's blood sugars were usually elevated. -He could not say for sure how many times the facility had called when Resident # 1's blood sugars were high because he was only on call four times a month, but they did have a call in system in place. Interview with the Administrator on 04/04/19 at 4:10 pm revealed: -If the MAs were not sure about an order or had questions, she expected them to talk with her, talk with the RCC or call the PCP for clarification.	D 344		

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D 344	Continued From page 18 -The facility staff currently did not have a system of comparing orders to MARs and following up with the physician. b. Review of Resident #1's current FL2 dated 03/25/19 revealed there was a physician's order for gabapentin 600 mg every night (used to treat seizures and peripheral nerve pain). Review of Resident #1's physician's order dated 09/17/18 and 03/04/19 revealed there was an order for gabapentin 600 mg, one tablet once daily at 6:00 am and gabapentin 600 mg, 4 tabs (2400 mg) at bedtime. Review of Resident #1's March 2019 medication administration record (MAR) revealed: -There was an entry for gabapentin 600 mg 1 tablet once daily scheduled at 6:00 am. -Gabapentin was documented as administered at 6:00 am from 03/01/19 to 03/31/19. -There was an entry for gabapentin 600 mg 4 tablets at bedtime scheduled at 7:00 pm. -Gabapentin was documented as administered at 7:00 pm from 03/01/19 to 03/31/19. Review of Resident #1's April 2019 MAR revealed: -There was an entry for gabapentin 600 mg 1 tablet once daily scheduled at 6:00 am. -Gabapentin was documented as administered at 6:00 am from 04/01/19 to 04/03/19. -There was an entry for gabapentin 600 mg 4 tablets at bedtime scheduled at 7:00 pm. -Gabapentin was documented as administered at 7:00 pm from 04/01/19 to 04/03/19. Observation on 04/04/19 at 6:10pm of Resident # 1's medications on hand revealed: -There was a bubble pack labeled gabapentin	D 344		

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600 mg 1 tablet once daily available for administration.
-There was a bubble pack labeled gabapentin 600 mg 4 tablets at bedtime available for administration.

Interview with the RCC on 04/04/19 at 6:25 pm revealed:
-The gabapentin 600 mg 1 tablet daily was being administered at 6:00 am.
-The gabapentin 600 mg 4 tablets daily were being administered at 7:00 pm.
-She did not know the orders on the FL2 dated 03/25/19 was different than the subsequent orders dated 03/04/19.
-She would need to clarify the order for gabapentin.

Telephone interview with Resident #1's primary care physician on 04/04/19 at 6:46 pm revealed:
-He had signed the subsequent orders on 03/04/19.
-He had signed the FL2 dated 03/25/19.
-The facility staff always gave him paperwork and orders to sign, but he did not realize Resident #1's gabapentin dosage was different than the subsequent orders he had signed on 03/04/19.
-The facility staff should have called to let him know and he would have clarified the orders.
-He wanted Resident #1 to take the gabapentin 600 mg one time a day in the morning and the gabapentin 600 mg 4 tabs at night.

Interview with Resident #1 on 04/04/19 at 7:45 pm revealed:
-He took gabapentin for the numbness in his legs and feet.
-He took one pill in the morning and 4 pills at night, but he was unsure of the dosage.
-He did not know of any change in the amount of

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D 344	Continued From page 20 his medication. Interview with the Administrator on 04/04/19 at 7:55 pm revealed: -She did not know the FL2 dated and signed by the physician on 03/25/19 had a different order for gabapentin than the 03/03/19 order. -Resident #1 had been getting the dosage that was in the physician's order prior to the FL2 dated 03/25/19. -The changed dosage on gabapentin medications on 03/25/19 should have been caught by the RCC, because the MAR should match the FL2. c. Review of Resident #1's current FL2 dated 03/25/19 revealed there was a physician's order for lopressor (metoprolol tartrate) 25 mg twice a day (used to treat high blood pressure). Review of Resident #1's physician's order dated 09/17/18 and 03/04/19 revealed there was an order for metoprolol tartrate 25 mg, take ½ tablet (12.5 mg) twice daily. Review of Resident #1's March 2019 medication administration record (MAR) revealed: -There was an entry for metoprolol tartrate 25mg take ½ tablet (12.5 mg) twice a day scheduled at 6:00 am and 7:00 pm. -Metoprolol tartrate was documented as administered twice a day from 03/01/19 to 03/31/19. Review of Resident #1's April 2019 MAR revealed: -There was an entry for metoprolol tartrate 25mg take ½ tablet (12.5 mg) twice a day scheduled at 6:00 am and 7:00 pm. -Metoprolol tartrate was documented as administered twice a day from 04/01/19 to	D 344		

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D 344	Continued From page 21 04/03/19. Observation on 04/04/19 at 6:10pm of Resident # 1's medications on hand revealed there was a bubble pack labeled metoprolol tartrate 25 mg take ½ tablet (12.5 mg) twice daily available for administration. Interview with the RCC on 04/04/19 at 6:25 pm revealed: -The metoprolol tartrate 25 mg, ½ tab was being administered twice daily at 6:00 am and 7:00 pm. -She did not know the orders on the FL2 dated 03/25/19 was different than the subsequent orders dated 03/04/19. -She would need to clarify the order for metoprolol tartrate. Telephone interview with Resident #1's primary care physician on 04/04/19 at 6:46 pm revealed: -He had signed the subsequent orders on 03/04/19. -He had signed the FL2 dated 03/25/19. -The facility staff always gave him paperwork and orders to sign, but he did not realize Resident #1's metoprolol tartrate dosage was different than the subsequent orders he had signed on 03/04/19. -The facility staff should have called to let him know and he would have clarified the orders. -He wanted Resident #1 to take the metoprolol 25 mg ½ tab every morning and ½ tab every night. Interview with Resident #1 on 04/04/19 at 7:45 pm revealed: -He took 1/2 pill in the morning and one 1/2 pill at night for his blood pressure, but he was not sure of the name of the medicine or the milligram dosage of the medicine. -He did not know of any change in the amount of	D 344		

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D 344	Continued From page 22 his medication. Interview with the Administrator on 04/04/19 at 7:55 pm revealed: -She did not know the FL2 dated and signed by the physician on 03/25/19 had a different order for metoprolol tartrate than the 03/03/19 order. -Resident #1 had been getting the dosage that was in the physician's order prior to the FL2 dated 03/25/19. -The changed dosage for metoprolol tartrate on 03/25/19 should have been caught by the RCC, because the MAR should match the FL2.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION	D 358	a) The RN consultant will monitor medication aides through medication pass observations to assure medications are administered as ordered by the prescribing physician. b) The facility medication aides were in-serviced on documentation of FSBS and insulin administration and documentation with emphasis on SSI. c) The Administrator and/or RCC will conduct weekly MAR reviews for one month to assure FSBS and insulins are documented and administered correctly, then monthly for three months and at least quarterly thereafter.	05/17/2019 Inservice 04/10/2019 Weekly 04/08/2019 thru 05/07/2019 monthly 05/08/2019 thru 08/07/2019 and quarterly thereafter

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D 358	Continued From page 23 Based on observations, record reviews and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (Residents # 1 and #2) with orders for sliding scale insulin (SSI); (Resident #3) with orders for an anti-anxiety medication and (Resident #1) with orders for a antihypertensive and neuropathy medication. The findings are: 1. Review of Resident #1's current FL2 dated 03/25/19 revealed: - Diagnoses included diabetes mellitus, acute respiratory failure with hypoxia, muscle weakness, chronic kidney disease (stage 3), chronic obstructive pulmonary disorder with exacerbation, pneumonia, and chronic pain. a. Review of Resident #1's current FL2 dated 03/25/19 revealed: There was a physician's order for fingerstick blood sugar (FSBS) before meals scheduled for 6:00 am, 11:30 am, 4:30 pm, and at night scheduled for 8:00 pm. -There was a physician's order for Novolog sliding scale insulin (SSI) (a rapid-acting insulin used to lower elevated blood sugar levels) before meals with parameters to inject insulin for FSBS 150-200, administer 4 units; 201-250, administer 6 units; 251-300, administer 8 units; 301-350, administer 10 units; 351-400, administer 12 units; 401 or greater, administer 14 units; recheck in one hour; if still greater than 400, give 10 additional units. Review of Resident #1's physician's order dated 09/17/18 revealed Novolog SSI before meals with parameters as follows:	D 358		

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D 358	Continued From page 24 -If fingerstick blood sugar (FSBS) was 150-200, administer 4 units of SSI. -If FSBS was 200-250, administer 6 units of SSI. -If FSBS was 251-300, administer 8 units of SSI. -If FSBS was 301-350, administer 10 units of SSI. -If FSBS was 350-400, administer 12 units of SSI. -If FSBS was 401 or greater, administer 14 units of Novolog SSI and recheck FSBS in one hour. -If FSBS was still 401 or greater, administer 10 units of SSI. Review of Resident #1's physician's orders dated 02/26/19 and 03/4/19 revealed a change in SSI before meals with parameters as follows: -If FSBS was 150-200, administer 6 units of SSI. -If FSBS was 201-250, administer 8 units of SSI. -If FSBS was 251-300, administer 10 units of SSI. -If FSBS was 301-350, administer 12 units of SSI. -If FSBS was 351 -400, administer 14 units of SSI. -If FSBS was greater than 400, administer 16 units of SSI. -If FSBS was still greater than 400, recheck FSBS in two hours, and if it remained greater than 400, administer 10 units of SSI. Review of Resident #1's February 2019 medication administration record (MAR) revealed: -There was an entry for FSBS to be checked and recorded four times a day scheduled at 6:00 am, 11:30 am, 4:30 pm, and 8:00 pm. -There was an entry for Novolog SSI to be administered when checking and recording FSBS before meals at 6:00 am, 11:30 am, and 4:30 pm. -There was an entry for SSI parameters as follows: 150-200 =4 units, 201-250=6 units, 250-300 =6 units, 301-350 =10 units, 351-400 =12 units, 401 or greater =14 units and recheck in one hour, if FSBS remained at 400 or greater, give 10 units.	D 358		

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D 358	Continued From page 25 - There was a second entry dated 02/26/19 for SSI with parameters as follows: 150-200 =6 units, 201-250 =8 units, 251-300 =10 units, 301-350 =12 units, 351-400 =14 units, and if FSBS remained greater than 400 =16 units. -FSBS ranged from 220 to 554 from 02/01/19 to 02/28/19. -There were 8 of 84 opportunities where the incorrect dose of Novolog SSI was documented as administered as follows: -On 02/19/19 at 11:30 am, Resident # 1's FSBS was documented as 416 and he was administered 8 units of Novolog instead of 14 units. -On 02/21/19 at 11:30 am, FSBS was 354, 8 units was documented as administered instead of 12 units. -On 02/21/19 at 4:30 pm, there was no FSBS documented, and 12 units were documented as administered. -On 02/23/19 at 6:00 am, FSBS was 230, 4 units were documented as administered instead of 6 units. -On 02/23/19 at 11:30 am, FSBS was 290, 6 units was documented as administered instead of 8 units. -On 02/24/19 at 11:30 am, FSBS was 245, 10 units was documented as administered instead of 6 units. -On 02/26/19 at 6:00 am, FSBS was 246, 6 units was documented as administered instead of 8 units. -On 02/27/19 at 6:00 am, FSBS was 432, 10 units was documented as administered instead of 16 units. -There were 11 occasions FSBS was over 400 and no documentation of FSBS recheck in one hour as follows:. -On 02/02/19 at 4:30 pm, FSBS was 404. -On 02/06/19 at 6:00 am, FSBS was 414.	D 358		

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D 358	Continued From page 26 -On 02/09/19 at 6:00 am, FSBS was 408; at 11:30 am, FSBS was 496, and at 4:30 pm FSBS was 448. -On 02/11/19 at 4:30 pm FSBS was 413. -On 02/13/19 at 11:30 am, FSBS was 437. -On 02/16/19 at 11:30 am, FSBS was 422. -On 02/18/19 at 11:30 am, FSBS was 460. -On 02/19/19 at 11:30 am, FSBS was 416. -On 02/27/19 at 6:00 am, FSBS was 432. -There were 2 occasions FSBS was over 401 after FSBS recheck with no documentation of administration of an additional 10 units of SSI as follows: -On 02/08/19 at 11:30 am, FSBS was 447 with documentation of a recheck at 12:30 pm of 448 and at 1:30 pm FSBS result of 487 with no documentation of administration of 10 additional units of SSI. Review of Resident #1's March 2019 MAR revealed: -There was an entry for FSBS to be checked and recorded four times a day scheduled at 6:00 am, 11:30 am, 4:30 pm, and 8:00 pm. -There was an entry for Novolog SSI to be given when checking and recording FSBS before meals at 6:00 am, 11:30 am, and 4:30 pm. - There was an entry for SSI with parameters as follows: 150-200 =4 units, 201-250 =6 units, 251-300 =8 units, 301-350 =10 units, 351-400 =12 units, and if FSBS remained greater than 400 =10 units. -FSBS results ranged from 178 to 445 from 03/10/19 to 03/31/19. -There were 72 of 93 occasions from 03/01/19 through 03/24/19 where the incorrect dose of Novolog was documented as administered with examples as follows: -On 03/01/19 at 6:00 am, FSBS was 305, 10 units were documented as administered instead of 12	D 358		

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D 358	Continued From page 27 units; at 11:30 am, FSBS was 338, 10 units were documented as administered instead of 12 units; and at 4:30 pm, FSBS was 259, 8 units were documented as administered instead of 10 units. -On 03/02/19 at 6:00 am, FSBS was 445, 14 units were documented as administered instead of 16 units; at 11:30 am, FSBS was 385, 12 units were documented as administered instead of 14 units; and at 4:30 pm, FSBS was 294, 8 units were documented as administered instead of 10 units. -On 03/04/19 at 6:00 am, FSBS was 275, 8 units were documented as administered instead of 10 units; at 11:30 am, FSBS was 309, 8 units were documented as administered instead of 12 units; and at 4:30 pm, FSBS was 325, 10 units were documented as administered instead of 12 units. -On 03/05/19 at 6:00 am, FSBS was 326, 10 units were documented as administered instead of 12 units; at 11:30 am, FSBS was 296, 8 units were documented as administered instead of 10 units; and at 4:30 pm, FSBS was 420, 14 units were documented as administered instead of 16 units. -On 03/07/19 at 6:00 am, FSBS was 333, 10 units were documented as administered instead of 12 units; at 11:30 am, FSBS was 330, 10 units were documented as administered instead of 12 units; and at 4:30 pm, FSBS was 410, 14 units were documented as administered instead of 16 units. -On 03/09/19 at 6:00 am, FSBS was 326, 10 units were documented as administered instead of 12 units; at 11:30 am, FSBS was 308, 10 units were documented as administered instead of 12 units; and at 4:30 pm, FSBS was 347, 10 units were documented as administered instead of 12 units. -On 03/12/19 at 6:00 am, FSBS was 352, 12 units were documented as administered instead of 14 units; at 11:30 am, FSBS was 258, 8 units were documented as administered instead of 10 units; and at 4:30 pm, FSBS was 322, 8 units were documented as administered instead of 12 units.	D 358		

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D 358	Continued From page 28 -On 03/13/19 at 6:00 am, FSBS was 311, 10 units were documented as administered instead of 12 units; at 11:30 am, FSBS was 275, 8 units were documented as administered instead of 10 units; and at 4;30 pm, FSBS was 290, 8 units were documented as administered instead of 10 units. -On 03/16/19 at 6:00 am, FSBS was 388, 12 units were documented as administered instead of 14 units; at 11:30 am, FSBS was 336, 10 units were documented as administered instead of 12 units; at 4:30 pm, FSBS was 349, 10 units were documented as administered instead of 12 units. -On 03/18/19 at 6:00 am, FSBS was 317, 10 units were documented as administered instead of 12 units; at 11:30 am, FSBS was 337, 10 units were documented as administered instead of 12 units; at 4:30 pm, FSBS was 295, 8 units were documented as administered instead of 10 units. -On 03/19/19 at 6:00 am, FSBS was 305, 10 units were documented as administered instead of 12 units; at 11:30 am, FSBS was 181, 4 units were documented as instead of 6 units; at 4:30 pm, FSBS was 259, 8 units were documented as administered instead of 10 units. -On 03/22/19 at 6:00 am, FSBS was 400, 14 units were documented as administered instead of 16 units; at 11:30 am, FSBS was 248, 6 units were documented as administered instead of 8 units; at 4:30 pm, FSBS was 418, 14 units were documented as administered instead of 16 units. Interview with Resident #1 on 04/03/19 at 10:00 am revealed: -He was diabetic and facility staff checked his FSBS before meals and at night. -Staff checked his FSBS before meals and gave insulin based on his blood sugar readings. -Staff checked his FSBS at night, but there was no insulin given based on blood sugar readings. -The physician had seen his blood sugar readings	D 358		

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and had increased his long acting insulin "about one month ago".
-The staff were supposed to check his blood sugar again if it was higher than 400, but they did not always do that.
-He did not know the time frame of rechecking his blood sugar and did not know the orders for the sliding scale insulin.

Interview with the Resident Care Coordinator (RCC) on 04/04/19 at 4:10 pm revealed:
-She usually worked as the first shift medication aide (MA), but she would sometimes be there for second shift as well.
-Resident #1 had scheduled insulin at 7:00 pm, but no SSI was ordered for the 8:00 pm FSBS check.
-MAs were supposed to give the SSI based on the FSBS reading before meals, recheck the blood sugar in one hour and if it was still over 400, give additional units of SSI and document everything on the back of the MAR.
-She had not noticed the documentation was not being done on the back of the MAR regarding rechecking FSBS and the administration of the additional insulin.
-She had not considered clarifying how many times to recheck Resident # 1's blood sugar if it continued to be over 400 after the additional units of SSI were given.

Interview with the Administrator on 04/04/19 at 4:15 pm revealed:
-She expected the MAs to administer medications as ordered.
-If the MAs were not sure about an order or had questions, she expected them to talk with her or the RCC or call the PCP for clarification.
-The facility currently did not have a system of comparing orders to MARs and following up with

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D 358	Continued From page 30 the physician. Second interview with the RCC on 04/04/19 at 6:25 pm revealed she or the MAs were responsible for faxing medication orders to the pharmacy to be entered on the MARs. Telephone interview with Resident #1's primary care physician (PCP) on 04/04/19 at 6:46 pm revealed: -He did not know how the order was worded for FSBS and SSI administration. -If FSBS order was for four times a day, the order for SSI would normally apply to each time the FSBS was done. -The facility staff should have called to clarify the order because Resident #1's blood sugars were usually elevated. -He could not say for sure how many times the facility had called when Resident #1's blood sugars were high because he was only on call four times a month, but they did have a call in system in place. -If Resident #1's FSBS was over 400 after the SSI was administered, he usually liked for it to be checked within 1-2 hours to give it time to go back down. b. Review of Resident #1's current FL-2 dated 03/25/19 revealed there was a physician's order for gabapentin 600 mg every night (used to treat seizures and peripheral nerve pain). Review of Resident #1's physician's order dated 09/17/18 and 03/04/19 revealed there was an order for gabapentin 600 mg, one tablet once daily at 6:00 am and gabapentin 600 mg, 4 tabs (2400 mg) at bedtime. Review of Resident #1's March 2019 medication	D 358		

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D 358	Continued From page 31 administration record (MAR) revealed: -There was an entry for gabapentin 600 mg 1 tablet once daily scheduled at 6:00 am. -Gabapentin was documented as administered at 6:00 am from 03/01/19 to 03/31/19. -There was an entry for gabapentin 600 mg 4 tablets at bedtime scheduled at 7:00 pm. -Gabapentin was documented as administered at 7:00 pm from 03/01/19 to 03/31/19. Review of Resident #1's April 2019 MAR revealed: -There was an entry for gabapentin 600 mg 1 tablet once daily scheduled at 6:00 am. -Gabapentin was documented as administered at 6:00 am from 04/01/19 to 04/03/19. -There was an entry for gabapentin 600 mg 4 tablets at bedtime scheduled at 7:00 pm. -Gabapentin was documented as administered at 7:00 pm from 04/01/19 to 04/03/19. Observation on 04/04/19 at 6:10pm of Resident # 1's medications on hand revealed: -There was a bubble pack labeled gabapentin 600 mg 1 tablet once daily available for administration. -There was a bubble pack labeled gabapentin 600 mg 4 tablets at bedtime available for administration. Interview with the RCC on 04/04/19 at 6:25 pm revealed: -The gabapentin 600 mg 1 tablet daily was being administered at 6:00 am. -The gabapentin 600 mg 4 tablets daily were being administered at 7:00 pm. -She did not know the orders on the FL-2 dated 03/25/19 was different than the subsequent orders dated 03/04/19. -She would need to clarify the order for	D 358		

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D 358	Continued From page 32 gabapentin. Telephone interview with Resident #1's primary care physician on 04/04/19 at 6:46 pm revealed: -He had signed the subsequent orders on 03/04/19. -He had signed the FL-2 dated 03/25/19. -The facility staff always gave him paperwork and orders to sign, but he did not realize Resident #1's gabapentin dosage was different than the subsequent orders he had signed on 03/04/19. -The facility staff should have called to let him know and he would have clarified the orders. -He wanted Resident #1 to take the gabapentin 600 mg one time a day in the morning and the gabapentin 600 mg 4 tabs at night. Interview with Resident #1 on 04/04/19 at 7:45 pm revealed: -He took gabapentin for the numbness in his legs and feet. -He took one pill in the morning and 4 pills at night, but he was unsure of the dosage. -He did not know of any change in the amount of his medication. Interview with the Administrator on 04/04/19 at 7:55 pm revealed: -She did not know the FL-2 dated and signed by the physician on 03/25/19 had a different order for gabapentin than the 03/03/19 order. -Resident #1 had been getting the dosage that was in the physician's order prior to the FL-2 dated 03/25/19. -The changed dosage on gabapentin medications on 03/25/19 should have been caught by the RCC, because the MAR should match the FL-2. c. Review of Resident #1's current FL-2 dated 03/25/19 revealed there was a physician's order	D 358		

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D 358	Continued From page 33 for lopressor (metoprolol tartrate) 25 mg twice a day (used to treat high blood pressure). Review of Resident #1's physician's order dated 09/17/18 and 03/04/19 revealed there was an order for metoprolol tartrate 25 mg, take ½ tablet (12.5 mg) twice daily. Review of Resident #1's March 2019 medication administration record (MAR) revealed: -There was an entry for metoprolol tartrate 25mg take ½ tablet (12.5 mg) twice a day scheduled at 6:00 am and 7:00 pm. -Metoprolol tartrate was documented as administered twice a day from 03/01/19 to 03/31/19. Review of Resident #1's April 2019 MAR revealed: -There was an entry for metoprolol tartrate 25mg take ½ tablet (12.5 mg) twice a day scheduled at 6:00 am and 7:00 pm. -Metoprolol tartrate was documented as administered twice a day from 04/01/19 to 04/03/19. Observation on 04/04/19 at 6:10pm of Resident # 1's medications on hand revealed there was a bubble pack labeled metoprolol tartrate 25 mg take ½ tablet (12.5 mg) twice daily available for administration. Interview with the RCC on 04/04/19 at 6:25 pm revealed: -The metoprolol tartrate 25 mg, ½ tab was being administered twice daily at 6:00 am and 7:00 pm. -She did not know the orders on the FL-2 dated 03/25/19 was different than the subsequent orders dated 03/04/19. -She would need to clarify the order for	D 358		

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D 358	Continued From page 34 metoprolol tartrate. Telephone interview with Resident #1's primary care physician on 04/04/19 at 6:46 pm revealed: -He had signed the subsequent orders on 03/04/19. -He had signed the FL-2 dated 03/25/19. -The facility staff always gave him paperwork and orders to sign, but he did not realize Resident #1's metoprolol tartrate dosage was different than the subsequent orders he had signed on 03/04/19. -The facility staff should have called to let him know and he would have clarified the orders. -He wanted Resident #1 to take the metoprolol 25 mg ½ tab every morning and ½ tab every night. Interview with Resident #1 on 04/04/19 at 7:45 pm revealed: -He took 1/2 pill in the morning and one 1/2 pill at night for his blood pressure, but he was not sure of the name of the medicine or the milligram dosage of the medicine. -He did not know of any change in the amount of his medication. Interview with the Administrator on 04/04/19 at 7:55 pm revealed: -She did not know the FL-2 dated and signed by the physician on 03/25/19 had a different order for metoprolol tartrate than the 03/03/19 order. -Resident #1 had been getting the dosage that was in the physician's order prior to the FL-2 dated 03/25/19. -The changed dosage for metoprolol tartrate on 03/25/19 should have been caught by the RCC, because the MAR should match the FL-2.	D 358		

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D 358	Continued From page 35 2. Review of Resident #2's current FL2 dated 08/16/18 revealed: -Diagnoses included type II diabetes mellitus. -There was a physician's order for fingerstick blood sugars (FSBS) before meals and at bedtime. -There was a physician's order for Novolog sliding scale insulin (SSI) (a rapid-acting insulin used to lower elevated blood sugar levels) with parameters to inject insulin for FSBS 150-200= 4 units, 201-250=5 units, 251-300= 6 units, 301-350= 8 units, 351-400=10 units, greater than 400=12 units and recheck in one hour, if FSBS remains above 400 give 10 units of Novolog. Review of Resident #2's subsequent physician's order dated 09/21/18 revealed to check and record FSBS three times a day before meals and inject Novolog insulin based on sliding scale parameters of 150-200= 6 units, 201-250=7 units, 251-300= 8 units, 301-350= 10 units, 351-400=12 units, greater than 400=14 units, and recheck within two hours, if still greater than 400 give 12 units. Review of Resident #2's subsequent physician's order dated 03/04/19 revealed to check and record FSBS three times a day before meals and inject Novolog insulin based on sliding scale parameters of 150-200= 6 units, 201-250=7 units, 251-300= 8 units, 301-350= 10 units, 351-400=12 units, greater than 400=14 units, and recheck within two hours, if still greater than 400 give 12 units. Review of Resident #2's February 2019 Medication Administration Record (MAR) revealed: -There was an entry for FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm, and	D 358		

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D 358	Continued From page 36 8:00pm. -There was a second entry for Novolog insulin three times a day before meals scheduled at 6:30am, 11:30am, and 4:30pm with sliding scale parameters of 150-200= 6 units, 201-250=7 units, 251-300= 8 units, 301-350= 10 units, 351-400= 12 units, greater than 400= 14 units, and recheck within two hours. If still greater than 400 give 12 units. -There was documentation the incorrect units of Novolog was administered 12 of 84 opportunities from 02/01/19 through 02/28/19 as follows: -On 02/07/19 at 6:30am FSBS was 325, Novolog was not administered; 10 units should have been administered. -On 02/12/19 at 11:30am FSBS was 344, 8 units were documented as administered; 10 units should have been administered. -On 02/13/19 at 6:30am FSBS was 293, Novolog was not administered; 8 units should have been administered. -On 02/13/19 at 11:30am FSBS was 287, Novolog was not administered; 8 units should have been administered. -On 02/15/19 at 6:30am FSBS was 292, Novolog was not administered; 8 units should have been administered. -On 02/15/19 at 6:30am FSBS was 513, Novolog was not administered, 14 units should have been administered. -On 02/19/19 at 11:30am FSBS was 396, 8 units were documented as administered; 12 units should have been administered. -On 02/20/19 at 6:30am FSBS was 296, 6 units were documented as administered; 8 units should have been administered. -On 02/21/19 at 6:30am FSBS was 325, 12 units were documented as administered; 10 units should have been administered. -On 02/22/19 at 6:30am FSBS was 386, 14 units	D 358		

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were documented as administered; 12 units should have been administered.
-On 02/26/19 at 6:30am FSBS was 374, 14 units were documented as administered; 12 units should have been administered.

Review of Resident #2's March 2019 MAR revealed:
-There was an entry for FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm.
-There was a second entry for Novolog insulin three times a day before meals scheduled at 6:30am, 11:30am, and 4:30pm with sliding scale parameters of 150-200= 6 units, 201-250= 7 units, 251-300= 8 units, 301-350= 10 units, 351-400= 12 units, greater than 400= 14 units, and recheck within two hours, if still greater than 400 give 12 units.
-There was documentation the incorrect units of Novolog was administered 14 of 93 opportunities from 03/01/19 through 03/31/19 on the following dates:
-On 03/01/19 at 4:30pm FSBS was 202, 10 units were documented as administered; 7 units should have been administered.
-On 03/03/19 at 6:30am FSBS was 429, Novolog was not administered; 14 units should have been administered.
-On 03/04/19 at 6:30am FSBS was 503, Novolog was not administered; 14 units should have been administered.
-On 03/06/19 at 11:30am FSBS was 270, 7 units were documented as administered; 8 units should have been administered.
-On 03/12/19 at 6:30am FSBS was 247, 10 units were documented as administered; 7 units should have been administered.
-On 03/18/19 at 11:30am FSBS was 386, 9 units were documented as administered; 12 units

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should have been administered.
-On 03/18/19 at 4:30pm FSBS was 502, 12 units were documented as administered; 14 units should have been administered.
-On 03/19/19 at 11:30am FSBS was 207, 10 units were documented as administered; 7 units should have been administered.
-On 03/20/19 at 11:30am FSBS was 388, 9 units were documented as administered; 12 units should have been administered.
-On 03/22/19 at 6:30am FSBS was 462, 12 units were documented as administered; 14 units should have been administered.
-On 03/27/19 at 6:30am FSBS was 404, 12 units were documented as administered; 14 units should have been administered.
-On 03/27/19 at 11:30am FSBS was 136, 8 units were documented as administered; 0 units should have been administered.
-On 03/29/19 at 4:30pm FSBS was 401, 12 units were documented as administered; 14 units should have been administered.
-On 03/31/19 at 4:30pm FSBS was 228, Novolog was not administered; 7 units should have been administered.

Review of Resident #2's April 2019 MAR revealed:
-There was an entry for FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm.
-There was a second entry for Novolog insulin three times a day before meals scheduled at 6:30am, 11:30am, and 4:30pm with sliding scale parameters of 150-200= 6 units, 201-250= 7 units, 251-300= 8 units, 301-350= 10 units, 351-400= 12 units, greater than 400= 14 units, and recheck within two hours. If still greater than 400 give 12 units.
-There was documentation the incorrect units of

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D 358	Continued From page 39 Novolog was administered 1 of 9 opportunities from 04/01/19 through 04/03/19. -On 04/03/19 at 6:30am FSBS was 320, Novolog was not administered; 10 units should have been administered. Interview with Resident #2 on 04/04/19 at 3:41pm revealed: -He was a diabetic and facility staff checked his blood sugar four times a day. -He was administered insulin "three to four times" daily to help control his diabetes. -He did not know the name of the insulin and did not know the parameters of the sliding scale. -Resident #2 knew that he had "high blood sugars" that were greater than 500, but he did not know when his blood sugars were high until staff checked his FSBS. Interview with the Resident Care Coordinator on 04/04/19 at 11:40am revealed: -The mediation aides (MAs) were responsible for checking Resident #2's FSBS and administering the Novolog insulin according to the sliding scale on the MAR. -The MAs should document the units of insulin administered. -She did not check behind the MAs to ensure units of insulin administered were accurate. Interview with a first shift MA on 04/04/19 at 11:30am revealed: -Resident #2 was a diabetic and was ordered Novolog insulin sliding scale. -Resident #2's FSBS was checked at least two times on the first shift. -When he checked Resident #2's FSBS he administered Novolog insulin based on the sliding scale that was printed on the MAR. -He documented the FSBS reading on the MAR	D 358		

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and on the facility's FSBS reading sheet.
-He also documented the units of insulin administered on the MAR.
-To his knowledge no one checked behind the MAs to ensure the correct units of Novolog were administered.

Interview with a second shift MA on 04/04/19 at 5:51pm revealed:
-She checked Resident #2's FSBS in the evening before the dinner meal.
-If the FSBS was within range to administer Novolog insulin sliding scale she used the flex-pen.
-She documented the FSBS and the units of insulin administered on the MAR.
-No one checked behind her to ensure the units of insulin administered were correct with the sliding scale.

Interview with the Administrator on 04/04/19 at 4:01pm revealed:
-The MAs were responsible for checking Resident #2's FSBS and administering insulin as ordered.
-The facility currently did not have a system that checked behind the MAs to ensure sliding scale insulin was administered as ordered.

Second interview with the RCC on 04/04/19 at 6:25 pm revealed she or the MAs were responsible for faxing medication orders to the pharmacy to be entered on the MARs.

3. Review of Resident #3's current FL2 dated 11/15/18 revealed diagnoses included schizophrenia.

Review of Resident #3's physician's order dated 02/11/19 revealed an order for Ativan (used to

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D 358	Continued From page 41 treat anxiety) 0.5 mg 2 times a day. Review of Resident #3's February 2019 medication administration record (MAR) revealed there was no entry for Ativan 0.5 mg 2 times daily. Review of Resident #3"s March 2019 MAR revealed: -There was a computer printed entry for Ativan 0.5 mg 2 times a daily scheduled for 6:00 am and 7:00 pm. -Ativan was documented as administered at 6:00 am and 7:00 pm daily for 35 of 62 opportunities from 03/01/19 to 03/31/19. Review of Resident #3"s April 2019 MAR revealed: -There was a computer printed entry for Ativan 0.5 mg 2 times a daily scheduled for 6:00 am and 7:00 pm. -Ativan was documented as administered at 6:00 am and 7:00 pm daily for 5 of 5 opportunities from 04/01/19 to 04/03/19. Observation of Resident #3's medication on hand on 04/04/19 at 3:45 pm revealed: -There was no Ativan available for administration. -There were no controlled substance count sheets available for Ativan. Interview with Resident #3 on 04/03/19 at 10:13 am revealed the facility staff always gave him his medications. Telephone interview with a representative from the contracted pharmacy on 04/04/19 at 3:30 pm revealed: -The pharmacy had received an order for Ativan 0.5 mg 2 times a day for Resident #3. -The pharmacy could not dispense Ativan without	D 358		

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D 358	Continued From page 42 a written prescription which they had not received. -The pharmacy had tried to contact the physician 3 times for Ativan prescription but was unsuccessful. Attempted telephone interview with Resident #3's physician on 04/04/19 at 3:45 pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 04/03/19 at 5:30 pm revealed: -Her job duties included passing medications. -She had passed medications to Resident #3. -She did not recall giving Ativan to Resident #3 or signing the controlled substance count sheet for Ativan. -She did not know why she had documented giving Ativan to Resident #3. -The mental health physician had written an order for Ativan but had not provided a written prescription for Ativan. -She had called the physician several times regarding an Ativan prescription for Resident #3, but was not able to obtain a written prescription for him. -She did not document she had called the physician for Resident #3 regarding the Ativan. Interview with the Administrator on 04/04/19 at 6:00 pm revealed: -She did not know Ativan had been ordered for Resident #3, but was not given a written prescription. -She did not know Resident #3's MARs were signed, but he had not received Ativan. -She was responsible for ensuring medications were given as ordered by the physician. -She expected MA's to inform her of any medications that were not sent by the pharmacy.	D 358		

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D 358	Continued From page 43 -She expected all medication orders to be clarified if not understood. -She expected all medications to be given as ordered. Second interview with the RCC on 04/04/19 at 6:25 pm revealed she or the MAs were responsible for faxing medication orders to the pharmacy to be entered on the MARs. The facility failed to assure SSI was administered to Resident #1 and Resident #2 as ordered which resulted in 107 of 186 opportunities where incorrect doses of SSI were documented as administered which could cause possible hyperglycemia and worsening diabetic conditions. This failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 04/04/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 2, 2019.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication	D 367	a) The RN consultant will monitor medication aides through medication pass observations to assure medications are administered as ordered by the prescribing physician. Medication pass observations to include documentation of “as needed” medications, reason for giving, and effectiveness. b) The Administrator and/or RCC will conduct weekly MAR reviews for one month to assure the medication administration	05/17/2019 Weekly 04/08/2019 thru 05/07/2019

Continued

			records are accurate and complete.	Monthly 05/08/2019 thru 08/07/2019 and quarterly thereafter

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D 367	Continued From page 44 or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the medication administration records were accurate and complete for 2 of 5 sampled residents (#2 and #3) with orders Oxycodone as needed (PRN) (Resident #2) and ativan (Resident #3). The findings are: 1. Review of Resident #2's current FL2 dated 08/16/18 revealed: -Diagnoses included right leg amputation and orthopedic after care. -There was a physician's order for Oxycodone 5mg every 4 hours as needed (PRN) for pain. Review of Resident #2's subsequent physician's order dated 03/04/19 revealed an order for Oxycodone 5mg every 4 hours as needed for	D 367		

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D 367	Continued From page 45 pain. Review of Resident #2's February 2019 Medication Administration Record (MAR) revealed. -There was an entry for Oxycodone 5mg every four hours PRN. -There was documentation Oxycodone was administered 5 times between 02/15/19 through 02/28/19 with no specific time documented on the following dates: -On 02/15/19, 02/19/19, 02/26/19, twice on 02/27/19. -There were 2 documented entries on the MAR related to the reason, need and result why Oxycodone was administered. -There were no entries on for the other dates. Review of the February 2019 controlled substance administration record revealed: -There was documentation Oxycodone was administered 11 times between 02/15/19through 02/28/19 on the following dates and times: 02/15/19 at 6:15pm, 02/20/19 at 1:15am, 02/21/19 at 4:30pm, 02/26/19 at 9:00am, 02/26/19 at 1:00pm, 02/27/19 6:42am, 02/27/19 11:07am, 02/27/19 at 3:10pm, 02/27/19 at 7:10pm, 02/27/19 at 11:10pm, and 02/28/19 at 7:00am. Review of Resident #2's March 2019 MAR revealed. -There was an entry for Oxycodone 5mg every four hours PRN. -There was documentation Oxycodone was administered 26 times between 03/01/19 and 03/31/19. -There was no documented entries on the MAR related to the reason, need and result why Oxycodone was administered.	D 367		

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D 367	Continued From page 46 Review of the March 2019 controlled substance administration record revealed: -There was documentation Oxycodone was administered 29 entries from 03/01/19 through 03/15/19 on the following dates and times: 03/01/19 at 2:00am, 03/01/19 at 6:00am, 03/01/19 at 6:25pm, 03/01/19 at 11:30pm, 03/02/19 at 3:30am, 03/02/19 at 6:00am, 03/02/19 at 7:30am, 03/03/19 at 12:30am, 03/03/19 at 6:00am, 03/03/19 at 1:00pm, 03/04/19 at 6:00pm, 03/05/19 at 1:00pm, 03/05/19 at 6:00pm, 03/07/19 at 6:00pm, 03/07/19 at 6:00pm, 03/07/19 at 10:00pm, 03/08/19 at 6:05am, 03/08/19 at 6:30pm, 03/09/18 at 6:15am, 03/06/19 at 6:00pm, 03/10/19 at 7:00am, 03/11/19 at 7:00am, 03/11/19 at 4:42pm, 03/12/19 at 6:00pm, 03/13/19 at 6:00pm, 03/14/19 at 6:00am, 03/15/19 at 6:00pm, and 03/15/19 at 8:30pm. Review of Resident #2's April 2019 MAR revealed. -There was an entry for Oxycodone 5mg every four hours PRN. -There was no documented entry Oxycodone was administered. Review of the April 2019 controlled substance administration record revealed no Oxycodone was administered. Observation of Resident #2's medications on hand on 04/04/19 at 11:30am revealed: -Oxycodone was available for administration. -The medication was filled on 08/17/18 for a quantity of 30 tablets. -There were 29 tablets in the bubble pack container.	D 367		

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D 367	Continued From page 47 Interview with a pharmacist at the contract pharmacy on 04/04/19 at 12:00pm revealed: -Oxycodone was filled on 08/03/18 and quantity of 30 tablets were dispensed. -On 08/03/18 the administration instructions for Oxycodone were to administer one tablet at bedtime. -On 08/17/19 the order for Oxycodone was changed to PRN every four hours. -On 08/17/19 the pharmacy dispensed 30 Oxycodone tablets. Interview with Resident #2 on 04/04/19 at 3:41pm revealed: -He was admitted to the facility in August 2018. -He frequently had pain in his body. -He also had phantom pain where his right leg was amputated. -When he had pain he asked for pain medication and was administered Oxycodone. -He did not know how many times he asked for the medication in February, March and April2019, but thought he had asked for the medication at least once per day. Interview with the Resident Care Coordinator on 04/04/19 at 11:40am revealed: -She could not recall if Resident #2 was admitted to the facility with existing Oxycodone. -The Medication Aides (MAs) knew they were to complete PRN documentation on the MAR each time they administered Oxycodone to Resident #2. -The facility did not have a system of checking the MARs to ensure PRN documentation was completed. Interview with a MA on 04/04/19 at 5:51pm revealed: -She had administered Oxycodone to Resident	D 367		

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D 367	Continued From page 48 #2. -She knew PRN documentation had to be completed when she administered the medication. -There should be documentation on the back of the MAR to relate to her initials on the front of the MAR. -If there was no documentation on the MAR she completed the PRN documentation. -She had no reason why she did not complete the PRN documentation for administering Resident #2's Oxycodone. Interview with the Administrator on 04/04/19 at 4:01pm revealed: -She expected the MAs to complete required PRN documentation. -The facility did not have a system of checking MAR to ensure documentation was completed. 2. Review of Resident #3's current FL2 dated 11/15/18 revealed diagnoses included schizophrenia. Review of Resident #3's subsequent physician's orders revealed there was an order dated 02/11/19 for Ativan (used to treat anxiety) 0.5 mg 2 times a day. Review of Resident #3's record revealed there was no documentation of notifying the physician regarding the need for an Ativan prescription . Review of Resident #3's February 2019 medication administration record (MAR) revealed there was no entry for Ativan 0.5 mg 2 times daily. Review of Resident #3"s March 2019 MAR revealed: -There was a computer printed entry for Ativan	D 367		

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D 367	Continued From page 49 0.5 mg 2 times a daily scheduled for 6:00 am and 7:00 pm. -Ativan was documented as administered at 6:00 am and 7:00 pm daily for 35 of 62 opportunities from 03/01/19 to 03/31/19. Review of Resident #3"s April 2019 MAR revealed: -There was a computer printed entry for Ativan 0.5 mg 2 times a daily scheduled for 6:00 am and 7:00 pm. -Ativan was documented as administered at 6:00 am and 7:00 pm daily from 04/01/19 to 04/03/19. Telephone interview with a representative from the contracted pharmacy on 04/04/19 at 3:30 pm revealed: -The pharmacy had received an order for Ativan 0.5 mg 2 times a day for Resident #3 on 02/11/19. -The pharmacy could not fill Ativan without a hard prescription which they had not received. -The pharmacy had tried to contact the physician 3 times for the Ativan written prescription but was unsuccessful. -The pharmacy staff had made the facility staff aware that were unable to reach the physician. -The pharmacy had not dispensed Ativan for Resident #3. Interview with the Resident Care Coordinator (RCC) on 04/03/19 at 5:30 pm revealed: -Her job duties included passing medications. -She had passed medications to Resident #3. -The mental health physician had written an order for Ativan but had not written a prescription for Ativan. -She had called the physician several times regarding Ativan for Resident #3, but was not able to obtain a written prescription for him.	D 367		

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D 367	Continued From page 50 -She did not document she had called the physician for Resident #3 regarding the Ativan. Interview with the Administrator on 04/04/19 at 6:00 pm revealed: -She did not know Ativan had been ordered for Resident #3, but was not given a written prescription. -She expected all medication orders to be clarified if not understood. -She expected all medications to be given as ordered.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Medication Administration and Adult Care Homes Infection Prevention Requirements. The findings are: Based on observations, record reviews and	D912	a) The RN consultant will monitor medication aides through medication pass observations to assure medications are administered as ordered by the prescribing physician. Medication pass observations to include documentation of “as needed” medications, reason for giving, and effectiveness. b) The Administrator and/or RCC will conduct weekly MAR reviews for one month to assure the medication administration records are accurate and complete.	05/17/2019 Weekly 04/08/2019 thru 05/07/2019 Monthly 05/08/2019 thru 08/07/2019 and quarterly thereafter

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D912	Continued From page 51 interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (Residents # 1 and #2) with orders for sliding scale insulin (SSI); (Resident #3) with orders for an anti-anxiety medication and (Resident #1) with orders for a antihypertensive and neuropathy medication. [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 3 diabetic residents sampled (Residents # 1, #2 and #8) with orders for blood sugar monitoring resulting in sharing of glucometers between residents. [Refer to Tag 932 G.S. 131D-4.4A(b) Adult Care Homes Infection Prevention Requirements (Type B Violation)].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used	D932	a) The RN consultant conducted an in-service on Finger Stick Blood Sugars with and emphasis on infection control and precaution guidelines with all medication aides. b) The Administrator and RCC started glucometer audits on 04/07/2019. The Administrator and RCC will audit glucometers daily for two weeks, then weekly for one month and at least quarterly thereafter.	04/10/2019 Daily completed 05/02/2019 Weekly 05/09/2019 to 06/06/2019 Quarterly thereafter

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D932	Continued From page 52 to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by:	D932	c) A written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers was implemented in order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.	05/17/2019

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D932	Continued From page 53 TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 2 of 3 diabetic residents sampled (Residents # 1 and #8) with orders for blood sugar monitoring resulting in sharing of glucometers between residents. The findings are: Observation of a locked tool box with compartments on 04/04/19 at 3:30 pm revealed: -There were 16 glucometers stored in the locked box with one glucometer in each compartment. -Each compartment was labeled with residents' names. -The Brand A glucometers were labeled on the back with a small white piece of paper with residents' names. -There were disposal single use lancets for use for all the residents receiving finger stick blood sugars (FSBS). Review of the CDC (Center for Disease Control and Prevention) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Review of the cleaning and disinfection	D932		

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D932	Continued From page 54 instructions for the Brand A glucometer revealed the glucometer was intended to be used by a single person and should not be shared. Observation of a FSBS check for a resident on 04/03/19 at 11:30 am revealed: -The medication aide (MA) wore gloves to obtain the FSBS. -The MA retrieved a glucometer from the locked toolbox that was labeled with the resident's name. -The MA obtained a FSBS check using a lancing pen that contained 6 lancets and used proper infection prevention techniques. -The MA placed the glucometer back in the labeled compartment of the toolbox. 1. Review of Resident #1's current FL2 dated 03/25/19 revealed: -Diagnoses included diabetes mellitus. -There was an order to check FSBS before meals scheduled at 6:00 am, 11:30 am, 4:30 pm, and at night scheduled at 8:30 pm. Review of Resident #1's April 2019 medication administration record (MAR) revealed there was an entry to check FSBS before meals scheduled at 6:00 am, 11:30 am, 4:30 pm, and at night scheduled at 8:30 pm. Observation of the glucometer (Brand A) identified for Resident #1 revealed: -The compartment in the locked tool boxwas labeled with Resident #1's name. - The Brand A glucometer located in one compartment was labeled with Resident #1's name on the back of the glucometer, but the name was faded and not legible. -The date and time were not set correctly for the actual date and time.	D932		

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D932	Continued From page 55 Review of Resident #1's Brand A glucometer's history on 04/04/19 at 2:39 pm revealed: - FSBS values were inconsistent compared to values documented on Resident #1's April 2019 MAR. -FSBS values documented on Resident #1's April 2019 MAR were not recorded in Resident #1's glucometer history with examples of inconsistencies as follows:. -There were 5 FSBS readings that were documented on the MAR that were not in Resident #1's glucometer history. -On 04/02/19, FSBS value of 296 at 11:30 am, FSBS value of 207 at 4:30 pm, and FSBS value of 119 at 8:30 pm were documented on the MAR, but not in Resident #1's glucometer history. -On 04/03/19, FSBS value of 259 at 6:30 am and FSBS value of 303 at 11:30 am were documented on the MAR, but not in Resident #1's glucometer history. -The values documented on the MAR for 04/02/19 at 11:30 am and at 4:30 pm and for 04/03/19 at 6:30 am and at 11:30 am matched values on the MAR for another resident. Interview with Resident #1 on 04/04/19 at 7:45 pm revealed: -He had his blood sugar checked before meals and at bedtime. -Each resident had their own glucometer in the box with their name on it. -The medication aide (MA) used the glucometer that had his name on it each time his blood sugar was checked. -Most of the time he saw the MA get the glucometer out of the locked box, which had his name on it as well. -He had never seen a MA use another resident 's glucometer to get his blood sugar reading.	D932		

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D932	Continued From page 56 Interview with the Resident Care Coordinator (RCC) on 04/04/19 at 4:10 pm revealed: -Her job duties included working as a MA. -She had checked finger stick blood sugars (FSBS) and administered insulin to Resident #1 Refer to interview with a Medication Aide (MA) on 04/04/19 at 7:30 pm. Refer to interview with the Resident Care Coordinator (RCC) on 04/04/19 at 7:50 pm. Refer to interview with the Administrator on 04/04/19 at 8:06 pm. 2. Review of Resident #8's current FL2 dated 03/04/19 revealed: -Diagnoses included diabetes mellitus and insulin dependent. -There was an order to check fingerstick blood sugar (FSBS) before meals scheduled at 6:00 am, 11:30 am, 4:30 pm, and at night scheduled at 8:30 pm. Review of Resident #8's April 2019 medication administration record (MAR) revealed there was an entry to check FSBS before meals scheduled at 6:00 am, 11:30 am, 4:30 pm, and at night scheduled at 8:30 pm. Observation of the glucometer (Brand A) identified for Resident #8 revealed: -The compartment in the locked tool box was labeled with Resident #8's name. - The Brand A glucometer located in one compartment was labeled with Resident #8's name on the back of the glucometer and was legible -The date and time were set correctly for the actual date and time.	D932		

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D932	Continued From page 57 Review of Resident #8's Brand A glucometer's history on 04/04/19 at 2:39 pm revealed FSBS values were inconsistent compared to values documented on Resident #8's April 2019 MAR. -FSBS values documented on Resident #8's April 2019 MAR were not recorded in Resident #8's glucometer history with examples of inconsistencies as follows: -On 04/02/19 at 11:30 am, the FSBS glucometer reading was 207, and there was no corresponding FSBS value recorded on the MAR. -There were 5 FSBS values documented on the MAR that were not in recorded in Resident #8's glucometer history. -On 04/02/19, FSBS value of 207 at 11:30 am, FSBS value of 191 at 4:30 pm, and FSBS value of 328 at 8:30 pm were documented on the MAR, but not recorded in Resident #8's glucometer history. -On 04/03/19, FSBS value of 152 at 6:30 am and FSBS value of 223 at 11:30 am were documented on the MAR, but not recorded in Resident #8's glucometer history. -The FSBS values documented on the MAR for 04/02/19 at 11:30 am and 4:30 pm and for 04/03/19 at 6:30 am and 11:30 am matched values on the MAR of another resident. Interview with Resident #8 on 04/04/19 at 7:30 pm revealed: -She got her blood sugar checked before meals and a night. -She thought her glucometer had her name on the front of it. -She did not think staff had ever checked her blood sugar with another resident's glucometer -She did not think her blood sugars ran as high as they used to.	D932		

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D932	Continued From page 58 Refer to interview with a Medication Aide (MA) on 04/04/19 at 7:30 pm. Refer to interview with the Resident Care Coordinator (RCC) on 04/04/19 at 7:50 pm. Refer to interview with the Administrator on 04/04/19 at 8:06 pm. Interview with a Medication Aide (MA) on 04/04/19 at 7:30 pm revealed: -She had checked finger stick blood sugars (FSBS) and administered insulin to residents. -To her knowledge, she always used the correct meter for each resident. Interview with the Resident Care Coordinator (RCC) on 04/04/19 at 7:50 pm revealed: -She had checked finger stick blood sugars (FSBS) and administered insulin to residents. -She had never used the wrong meter to check a residents FSBS, "if I had it was not intentional or for the sake of a shortcut". -She had never seen anyone using the wrong meter to do FSBS's. -She did not know glucometers were being used for more than one resident. -The glucometers were labeled with residents' names on the back of the glucometer as well as on the compartment of the locked box where they were kept. -Each resident had their own glucometer and glucometers were not to be shared. -It was possible that the labeled glucometer was placed back in another resident's compartment on the locked box. -She had seen a MA put a glucometer in another resident's compartment before, pointed it out and had the MA correct it, but did not remember the date.	D932		

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D932	Continued From page 59 Interview with the Administrator on 04/04/19 at 8:06 pm revealed: -She did not know glucometers were being used on more than one resident. -Glucometers were in a locked toolbox with labeled compartments for each resident. -Each glucometer had the residents name on it. -Some of the glucometers had been placed in the wrong compartments previously, but she had removed them and placed them in the appropriately labeled compartment. -She believed it was possible for the wrong glucometer to be used if someone wasn't paying attention. -There were no residents at the facility with a diagnosis of a bloodborne pathogen disease. -She expected glucometers to be placed in the correct resident assigned compartments. -She expected staff to check the name on the glucometer prior to using and ensure that it was for the correct glucometer for each resident. The facility failed to implement infection control procedures consistent with CDC guidelines placing residents receiving finger stick blood sugar checks with glucometers at risk due to possible exposure to bloodborne pathogen diseases for Residents #1 and #8. This failure was detrimental to the health safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/04/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 19, 2019.	D932		