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TWELVE OAKS	1297 GALAX TRAIL MOUNT AIRY, NC 27030

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 10/23/19 through 10/24/19.	D 000		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 3 of 4 staff sampled (Staff B, E and F) who administered insulin and obtained finger stick blood sugars for	D 164		

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residents completed training on care of the diabetic resident prior to the administration of insulin.

The findings are:

1. Review of Staff B's, Medication Aide (MA)/Supervisor personnel record revealed:
-Staff B was hired on 07/13/16 as Personal Care Aide.
-Staff B was moved into the MA position on 12/28/18.
-There was no documentation Staff B had completed training on care of the diabetic resident.

Review of a resident's October 2019 electronic Medication Administration Record (eMAR) revealed there was documentation Staff B obtained finger stick blood sugars (FSBS) 7 times and administered insulin 4 times from 10/01/19 to 10/24/19.

Interview with Staff B on 10/24/19 at 12:41pm revealed:
-She had worked at the facility since 2016 and started working as a MA in 2018.
-Her job duties included administering medication including insulin injections and checking FSBS.
-She did not remember having diabetic care training apart from the 5, 10 or 15 hour medication training and medication clinical skills validation.

Refer to interview with the Resident Care Coordinator (RCC) on 10/24/19 at 12:34pm.

Refer to interview with the Administrator on 10/24/19 at 6:15pm.

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2. Review of Staff E's, Medication Aide (MA)/Supervisor personnel record revealed:
-Staff E was hired on 11/02/17 as a MA/Supervisor.
-There was no documentation Staff E had completed training on care of the diabetic resident.

Review of a resident's October 2019 electronic Medication Administration Record (eMAR) revealed there was documentation Staff E obtained finger stick blood sugars (FSBS) and administered insulin 13 times from 10/01/19 to 10/24/19.

Attempted telephone interview with Staff E on 10/24/19 at 12:01pm was unsuccessful.

Refer to interview with the Resident Care Coordinator (RCC) on 10/24/19 at 12:34pm.

Refer to interview with the Administrator on 10/24/19 at 6:15pm.

2. Review of Staff F's, Medication Aide (MA) personnel record revealed:
-Staff F was hired on 12/27/17 as a Personal Care Aide.
-Staff F was moved into the MA position on 06/07/19.
-There was no documentation Staff F had completed training on care of the diabetic resident.

Review of a residents' October 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff F obtained finger stick blood sugars (FSBS) and administered insulin 6 times from 10/01/19 to 10/24/19

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D 164	Continued From page 3 Interview with Staff F on 10/24/19/19 at 1:05pm revealed: -He had worked as a MA since June 2019. -His job responsibilities included administering medication including insulin injections and checking FSBS. -He though he had diabetic training when he became a MA, but he was not sure if it was a training separate from his 5, 10 or 15 hour medication training and medication clinical skills validation. -He did not know if he had a certificate for diabetic care training. Refer to interview with the Resident Care Coordinator (RCC) on 10/24/19 at 12:34pm. Refer to interview with the Administrator on 10/24/19 at 6:15pm. _____ Interview with the Resident Care Coordinator (RCC) on 10/24/19 at 12:34pm revealed: -She was responsible for making sure training was completed on care of the diabetic resident. -She thought the diabetic care training covered in the 5, 10 or 15 hour medication training was sufficient. -She did not know there should have been a separate training for care of the diabetic resident and had not scheduled a training for any MA for care of the diabetic resident. Interview with the Administrator on 10/24/19 at 6:15pm revealed: -The RCC was responsible for making sure the training on the care of the diabetic resident was completed for staff. -She was under the impression the 5, 10 or 15 hour medication training covered diabetic care	D 164		

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D 164	Continued From page 4 and did not know there needed to be a separate training on the care of the diabetic resident. -She would make sure a training was completed for MAs on the care of the diabetic resident.	D 164		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (Resident #8 and #9) related to a medication for anxiety(#9) and low vitamin D levels (#8) during the 8:00 am medication pass on 10/24/19 and 2 of 3 sampled residents (#6 and #8) for record review related to a blood thinner (#6) and a nasal spray for allergies (8). The findings are: The medication error rate was 6% as evidenced by the observation of 2 errors out of 31 opportunities during the 8:00 am medication pass on 10/24/19. 1. Review of Resident #9's FL-2 dated 01/23/19 revealed: -Diagnoses included Lewy body dementia,	D 358		

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vitamin D deficiency, vitamin B12 deficiency, hypertension, and Capgras syndrome.
-There was an order for clonazepam (used to treat anxiety) 1 mg every night at bedtime.

Review of Resident #9's physician's order dated 02/28/19 revealed clonazepam 1 mg every morning and every night.

Review of Resident #9's physician orders dated 05/02/19 revealed clonazepam 1 mg twice a day.

Observation of the 8:00 am medication pass in the Special Care Unit (SCU) on 10/24/19 revealed:
-At 8:26 am, the medication aide (MA) pulled 11 medications for Resident #9, excluding clonazepam, from the medication cart.
-Each medication was verified and punched into a cup one at a time.
-There were 11 tablets in the medication cup.
-Clonazepam was not in the medication cup.
-The MA added applesauce to the medications and administered them at 8:34 am.
-The MA signed off on administering 12 medications for 8:00 am including clonazepam.

Review of Resident #9's October 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 1 mg twice a daily scheduled for 8:00 am and 8:00 pm.
-Clonazepam was documented as administered for 8:00 am on 10/24/19.

Interview with the MA on duty in the SCU on 10/10/19 at 4:40 pm revealed:
-She administered 8:00 am medications to Resident #9 on 10/24/19.
-Clonazepam was not available on the cart on

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D 358	Continued From page 6 10/24/19. -She reordered clonazepam from the pharmacy during the 8:00 am medication pass, but she thought it had been previously ordered. -She did not work the previous morning on 10/23/19. -Controlled substances could only be ordered a few days before the last dose. -She completed a physician's order sheet and faxed it to the contracted pharmacy. Based on observations, interviews, and record reviews, it was determined Resident #9 was not interviewable. Interview with the Resident Care Coordinator (RCC) on 10/24/19 at 11:50 am revealed: -She did not know Resident #9 was out of clonazepam. -Each MA was responsible for administering all medications on their shift. -Random cart audits were completed to ensure medications were present on the medication cart. -She expected each MA to administer medications timely and correctly. Interview with the Administrator on 10/24/19 at 12:05 pm revealed: -She did not know Resident #9 was out of clonazepam. -The facility "QM" department came monthly to complete whole cart to eMAR reviews. -The facility would investigate why the resident ran out of clonazepam and did not have any on hand. -She expected the MAs to administer medications as ordered per policy and procedures. Interview with Resident #9's primary care physician on 10/24/19 at 12:51 pm revealed:	D 358		

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-He did not know that Resident #9 missed a dose of clonazepam.
-He would send a new prescription for clonazepam for Resident #9.
-A missed dose of clonazepam could slightly increase anxiety temporarily for Resident #9.

Telephone interview with the contracted pharmacy representative on 10/24/19 at 5:01 pm revealed:
-Controlled substances could only be reordered 3-4 days prior to the last dose.
-Controlled substances must be reordered manually meaning the facility staff had to send refill information.
-The refill request for Resident #9's clonazepam was received today on 10/24/19.
-Resident #9 was out of refills and needed a new prescription from the primary care physician.
-There were 60 tablets of clonazepam last dispensed on 09/23/19 and should have lasted 30 days.

2. Review of Resident #8's FL-2 dated 03/01/19 revealed:
-Diagnoses included Alzheimer's dementia, diabetes mellitus type 2, hypertension, gout, chronic kidney disease, anemia, and gastroesophageal reflux disorder.

a. Review of Resident #8's FL-2 dated 03/01/19 revealed an order for vitamin D3 (used to treat vitamin D deficiency) 1,000 units every morning.

Review of Resident #8's physician's orders dated 05/02/19 revealed vitamin D3 1,000 units every morning.

Observation of the 8:00 am medication pass on 10/24/19 revealed:

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D 358	Continued From page 8 -At 8:04 am, the medication aide (MA) prepared medications for Resident #8, including vitamin D 5,000 units, for administration to Resident #8. -The MA administered the medications at 8:09 am. Review of Resident #8's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin D3 1,000 units every morning scheduled for 8:00 am. -Vitamin D3 1,000 units was documented as administered for 8:00 am on 10/24/19. Interview with Resident #8 on 10/24/19 at 11:00 am revealed: -He did not know what dosage of vitamin D the physician ordered for him. -His family or his pharmacy sent the vitamin D for him. Interview with the MA on 10/10/19 at 11:46 am revealed: -She administered 8:00 am medications to Resident #8 on 10/24/19. -She administered vitamin D from the bottle the family brought for Resident #8. -She did not double check the dosage of the vitamin D on the bottle compared to the eMAR. -It was her responsibility to ensure medications were administered correctly as ordered by the physician. Interview with the Resident Care Coordinator (RCC) on 10/24/19 at 11:50 am revealed: -She did not know Resident #8's vitamin D 5,000 units was administered instead of the ordered dose of 1,000 units. -MAs were responsible for checking dosages of vitamins when a family member supplied them.	D 358		

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D 358	Continued From page 9 -Each MA was responsible for checking the dosage of a medication before it was administered. -She expected each MA to administer medications correctly. Interview with the Administrator on 10/24/19 at 12:05 pm revealed: -She did not know Resident #8's vitamin D 5,000 units was administered instead of the ordered dose of 1,000 units. -MAs were responsible for checking dosages of medications when supplied by family members. -She expected the MAs to administer medications as ordered per policy and procedures. Interview with Resident #8's primary care physician on 10/24/19 at 12:51 pm revealed: -He had ordered vitamin D 1,000 units daily for Resident #8. -He would not order vitamin D 5,000 units a day for any resident. -He would have to check Resident #8's vitamin D level. -There was no harm in taking vitamin D 5,000 units daily. b. Review of Resident #8's FL-2 dated 03/01/19 revealed an order for fluticasone (used to treat nasal allergies) 50 mcg instill 2 sprays each nostril daily as needed for rhinitis. Review of Resident #8's physician's order dated 05/02/19 revealed fluticasone 50 mcg instill 2 sprays each nostril daily as needed for rhinitis. Review of Resident #8's physician's order dated 09/10/19 revealed fluticasone 50 mcg instill 2 sprays each nostril daily.	D 358		

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D 358	Continued From page 10 Review of Resident #8's September 2019 electronic medication administration record (eMAR) revealed: -There was an entry for fluticasone 50 mcg instill 1 spray each nostril daily scheduled for 8:00 am. (This entry included an RX number.) -Fluticasone 50 mcg 1 spray was documented as administered daily from 09/11/19 to 09/30/19. -There was an entry for Flonase use 2 sprays each nostril daily scheduled for 9:00 am. (This entry did not have an RX number.) -Flonase 2 sprays was documented as administered daily from 09/11/19 to 09/30/19. Observation of Resident #8's medications on hand on 10/24/19 at 11:12 am revealed: -There was 1 partially filled bottle of fluticasone 50 mcg nasal spray with labeling that read equivalent to Flonase. -The fluticasone was kept in a plastic baggie and locked in the treatment cart. -There was no fluticasone or Flonase located in the medication cart. Review of Resident #8's October 2019 electronic medication administration record (eMAR) revealed: - There was an entry for fluticasone 50 mcg instill 1 spray each nostril daily scheduled for 8:00 am. (This entry included an RX number.) -Fluticasone 50 mcg 1 spray was documented as administered daily from 10/01/19 to 10/23/19. -There was an entry for Flonase use 2 sprays each nostril daily scheduled for 9:00 am. (This entry did not have an RX number.) -Flonase 2 sprays was documented as administered daily from 10/01/19 to 10/23/19. Interview with Resident #8 on 10/24/19 at 11:00 am revealed:	D 358		

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D 358	Continued From page 11 -He was prone to sinus infections due to his nasal allergies. -He knew he used a nasal spray for allergies. -He did not know what dosage of fluticasone the physician ordered for him. -He did not know how many times a day he used the nasal spray. Interview with the MA on 10/10/19 at 11:46 am revealed: -She routinely administered medications to Resident #8. -She had administered fluticasone 50 mcg 1 spray to each nostril to Resident #8. -She had administered Flonase 2 sprays to each nostril to Resident #8. -She did not know fluticasone was a generic nasal spray equivalent to Flonase. -She believed she had been administering the medication after completing her medication pass when she did treatments at 8:30 am and again for 9:00 am. -It was her responsibility to ensure she administered medications correctly. Interview with the Resident Care Coordinator (RCC) on 10/24/19 at 11:50 am revealed: -She routinely entered temporary medication orders in the computer, but on weekends if she was not available the supervisor entered them into the computer. -Upon receiving an order, the RCC or Supervisor would enter it into the computer eMAR without an RX number and fax the order to the pharmacy. If the pharmacy was closed a second supervisor or medication aide (MA) had to verify the order. -When the pharmacy received the order, the pharmacy representative would enter the order into the eMAR with an RX number. -The facility would then have to verify the order	D 358		

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entered into the computer by the pharmacy representative.
-After the order containing the RX number was verified, the RCC or supervisor would discontinue the temporary order, the one with the RX number.
-She did not know Resident #8 had a duplicate order of fluticasone until 10/24/19.
-She reviewed the fluticasone and Flonase orders on the eMAR and determined the evening supervisor did not discontinue the temporary order (the one without an RX number).
-Each MA was responsible for checking the medication for the correct dosage and route and to ensure the medication was not duplicated.
-She completed eMAR audits randomly.
-She expected each MA to administer medications correctly.

Interview with the Administrator on 10/24/19 at 12:05 pm revealed:
-She did not know Resident #8 had a duplicate order of fluticasone nasal spray.
-New orders were faxed to the pharmacy and set to the side until a "pending" order showed in the eMAR system.
-The order then had to be verified or denied by the MA or supervisor.
-The RCC completed a final check to ensure the medication was in the building and to ensure the eMAR was correct.
-She expected the MAs to administer medications as ordered per policy and procedures.

Interview with Resident #8's primary care physician on 10/24/19 at 12:51 pm revealed:
-Resident #8 was ordered fluticasone 50 mcg 2 sprays each nostril daily.
-He did not know Resident #8 had been administered fluticasone 2 times daily since 09/11/19.

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-The maximum dosage for fluticasone was 2 sprays per day. Any more than 2 sprays each nostril per day could cause the resident to have nose bleeds.
-Any potential nose bleeds would stop upon using no greater than 2 sprays of fluticasone per nostril.
-He expected medications to be administered as ordered and not duplicated.

Interview with the evening MA/Supervisor on 10/24/19 at 2:38 pm revealed:
-She verified the fluticasone order (the one with the RX number) for Resident #8 on 09/10/19.
-She forgot to discontinue the Flonase order after she verified the order from the pharmacy (the one without RX number).
-The RCC was supposed to double check the order after it had been verified to ensure there was no duplications remaining on the eMAR.

Interview with a representative from the contracted pharmacy on 10/24/19 at 5:01 pm revealed:
-The pharmacy received an order for fluticasone 50 mcg 2 sprays each nostril daily on 09/10/19.
-The pharmacy entered the order for fluticasone on Resident #8's profile on 09/10/19, but the pharmacy did not dispense the medication as they had a note the family would provide medications.

2. Review of Resident #6's current FL2 dated 08/19/19 revealed diagnoses included Alzheimer's/dementia, renal insufficiency, and chronic obstructive pulmonary disease.
-There was a physician's order for aspirin EC (enteric coated) 325mg (used to prevent blood clots, reduce fever and pain) once daily.

Review of the physician's orders in Resident #6's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086008	A. BUILDING: _____ B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWELVE OAKS	1297 GALAX TRAIL 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 358	Continued From page 14 record revealed an order dated 10/09/19 with orders to crush all Resident #6's medications. There was also an order to change aspirin EC 325mg to aspirin 81mg chewable daily. Review of Resident #6's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for aspirin EC 325mg once daily at 8:00am. -There was documentation aspirin EC 325mg was administered at 8:00am 10/10/19 through 10/24/19. -There was no entry for aspirin 81 mg chewable. Observation on 10/24/19 at 10:20am of Resident #6's medications on hand revealed aspirin EC 325mg was available for administration. There was no aspirin 81mg available for Resident #6. Interview with the medication aide (MA) on duty revealed: -Resident #6 was unable to take her medications unless they were crushed. -She crushed all Resident #6's medications including the aspirin EC 325mg. -She did not know she could not crush the aspirin EC. -She did not know there was an order for aspirin 81mg chewable. Interview with a pharmacist at the contracted pharmacy revealed: -The pharmacy had not received orders to change aspirin EC 325mg to aspirin 81mg chewable. -The facility should not crush aspirin EC 325mg because it can cause stomach irritation to the resident.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 15 Based on record review, observation and attempt interview, it was determined Resident #6 was not interviewable. The Special Care Unit coordinator was unavailable for interview on 10/24/19. Interview with the Administrator on 10/24/19 at 12:10 pm revealed: -She did not know Resident #6 had an order that changed aspirin EC 325mg to aspirin 81mg chewable. -The staff receiving the order was to fax the order to the pharmacy. -The order had to be verified or denied by the MA or supervisor. -The RCC was to complete the final check to ensure the medication was in the building and to ensure the eMAR was correct. -She expected the MAs to administer medications as ordered per policy and procedures.	D 358		