Received via email 11/05/21, KHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032073	A. BUILDING: _____ B. WING _____	R 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN SPRING LIVING CENTER	3812 BOOKER STREET DURHAM, NC 27713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 09/28/21 through 09/29/21 with exit via telephone on 09/30/21.	D 000		
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 3 of 5 sampled residents (Residents #1, #4 and #5) with orders for insulin administration and fingerstick blood sugar (FSBS) within specified parameters. The findings are: 1. Review of Resident #1's current FL2 dated 09/13/21 revealed diagnoses included type 2 diabetes, cognitive communication deficit, amputation of both legs near the knees, chronic kidney disease and peripheral vascular disease. Review of Resident #1's physician orders dated 09/20/21 revealed there was an order for Novolog (a rapid-acting insulin used to lower elevated blood sugar levels) sliding scale insulin (SSI): 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, 401-450= 10 units, over	D 358		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jackson Odondi — TITLE: ADMINISTRATOR — (X6) DATE: 11/5/2021

Reviewed and Acknowledged 11/05/21 KHH

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D 358	Continued From page 1 450 call MD. Review of Resident #1's September 2021 eMAR revealed: -There was an entry for Novolog SSI to be administered 4 times daily with meals and at bedtime per sliding scale: 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, 401-450= 10 units, over 450 call MD scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was an entry for FSBS to be obtained four times daily scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was no FSBS documented on 09/22/21, instead a temperature was documented and it could not be determined if Resident #1's FSBS was within range for SSI. -On 09/24/21 at 8:00pm the FSBS was 240, required 2 units of Novolog insulin. There was no documentation SSI was administered. -On 09/26/21 at 8:00pm the FSBS was 220, required 2 units of Novolog insulin. There was no documentation SSI was administered. -There was documentation that 8 units of SSI was administered on 09/27/21 at 5:00pm for FSBS of 120 and at 8:00pm for FSBS of 120, and 09/28/21 at 8:00am for FSBS 120 and no SSI should have been administered. Interview with the medication aide (MA) on 09/29/21 at 11:10am revealed she was not sure why she some FSBS readings were not documented or why she documented temperatures in those spaces instead of the FSBS readings. Interview with the Administrator on 09/29/21 at 11:15am revealed: -There was no process in place to check the work	D 358		

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D 358	Continued From page 2 of the MAs to ensure medications were administered as ordered. -There was no system in place to compare FSBS readings in the glucometer history with documentation of FSBS on the eMARs to ensure FSBS documentation on the eMARs were accurate. Interview with Resident #1 on 09/29/21 at 2:15pm revealed: -Staff typically checked his FSBS and administered his insulin twice daily before breakfast and dinner but not always at lunch time. -Sometimes staff checked his FSBS a third or fourth time if his FSBS was low. Interview with a representative from the contracted pharmacy on 09/29/21 at 5:00pm revealed Resident #1 had an active order on file for FSBS checks four times daily and had a Novolog SSI order to be administered when FSBS was over 200. Attempted interview with Resident #1's primary care provider (PCP) on 09/29/21 at 2:55pm was unsuccessful. 2. Review of Resident #4's current FL2 dated 09/27/21 revealed: -Diagnoses included type 2 diabetes, hypertension, and hyperlipidemia. -There was a physician's order for Novolog (fast-acting insulin used to control diabetes) sliding scale insulin (SSI) before meals three times daily with parameters: 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, 401-450= 10 units, if blood sugar over 450 call MD. Review of Resident #4's September 2021	D 358		

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D 358	Continued From page 3 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog SSI scheduled at 7:30am, 11:30am, and 4:30pm. -There was an entry to check Resident #4's fingerstick blood sugar (FSBS) three times daily scheduled at 7:30am, 11:30am and 4:30pm. -There was documentation Novolog SSI was administered incorrectly 21 of 85 opportunities from 09/01/21 through 09/29/21 with examples as follows: -On 09/02/21, FSBS-180 at 7:30am, 35 units of SSI was documented as administered, and 0 units should have been administered. -On 09/02/21, FSBS-210 at 4:30pm, 35 units of SSI was documented as administered, and 2 units of SSI should have been administered in addition to 35 units of scheduled Novolog. -On 09/17/21, FSBS-320 at 11:30am, 4 units of SSI was documented as administered, 6 units should have been administered. -On 09/22/21, FSBS-225 at 5:30pm, 4 units of SSI was documented as administered, and 2 units should have been administered. -On 09/24/21, FSBS-214 at 7:30am, 26 units of SSI was documented as administered, and 2 units should have been administered. -On 09/24/21, FSBS-230 at 5:30pm, 0 units of SSI was documented as administered, and 2 units should have been administered. -On 09/25/21, FSBS-214 at 7:30am, 26 units of SSI was documented as administered, and 2 units should have been administered. -On 09/29/21, FSBS-217 at 7:30am, 24 units of SSI was documented as administered, and 2 units should have been administered. Interview with the medication aide (MA) on 09/29/21 at 11:10am revealed: -She was not sure why she documented some	D 358		

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D 358	Continued From page 4 FSBS as values other than what the glucometer showed. -She did not have an explanation for why the number of units of SSI administered did not match the order. -She thought she was supposed to document total units of scheduled and SSI administered, and not just the units of SSI administered. Interview with the Administrator on 09/29/21 at 11:15am revealed: -There was no process in place to check the work of the MAs to ensure medications were administered as ordered. -There was no system in place to compare FSBS readings in the glucometer history with documentation of FSBS on the eMARs to ensure FSBS documentation on the eMARs were accurate. Based on observation, record review and interview, it was determined Resident #4 was not interviewable. Attempted interview with Resident #4's primary care provider (PCP) on 09/29/21 at 2:55pm was unsuccessful. 3. Review of Resident #5's current FL2 dated 09/13/21 revealed diagnoses included diabetes. Review of Resident #5's physician's order revealed there was an order dated 09/20/21 for Novolog (a fast-acting insulin used to lower elevated blood sugar levels) sliding scale insulin (SSI) four times daily with parameters as follows: 201-250= 2 units; 251-300= 4 units; 301-350= 6 units; 351-400= 8 units; and 401-450= 10 units; and greater than 450 call physician.	D 358		

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D 358	Continued From page 5 a. Observation on 09/29/21 at 8:40am revealed: -The medication aide (MA) obtained Resident #5's morning FSBS. -The FSBS reading in the glucometer was 297. Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog SSI four times daily with parameters scheduled for administration 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was an entry for FSBS scheduled daily at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was documentation the MA documented the FSBS obtained on 09/29/21 at 8:40am as 180, instead 297 (glucometer reading). -There was no documentation the MA administered Novolog SSI 2 units as ordered. Interview with Resident #5 on 09/30/21 at 12:20pm revealed: -He just found out he was a diabetic a month and a half ago. -Previously his FSBS were in the 500's and he had to be hospitalized. -His FSBS were checked by the MA three times daily. -The MA told him the FSBS result, but he did not remember the result. -He was aware that he was ordered a SSI two weeks ago but was not aware of the parameters for the SSI. -After checking his FSBS the MA sometimes administered insulin, but he was not aware of the units of insulin administered. Interview with the MA on 09/29/21 at 10:59am revealed: -She checked the resident's FSBS this morning,	D 358		

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D 358	Continued From page 6 she was unable to recall the exact time. -She was unable to explain why she documented Resident #5's FSBS result at 8:51am on 09/29/21, this morning as 180 on the eMAR, instead of 297 reading which was in the glucometer. -She thought maybe she was not wearing her glasses when she obtained the FSBS. -She did not administer SSI to Resident #5 this morning based on the 180 FSBS that she documented on the eMAR. Interview with the Assistant Administrator (AA) on 09/29/21 at 11:05am revealed: -He checked the eMARs daily to ensure medications were administered. -He did not compare FSBS readings recorded in the glucometer histories with FSBS results documented on the eMAR to ensure the eMAR was accurate. Interview with the Administrator on 09/29/21 at 11:10am revealed: -He was unable to explain why the MA documented Resident #5's FSBS at 8:51am on the eMAR as 180 and the FSBS in the glucometer was 297. -He could ask the computer department if there was something wrong with the computer. -Once in a while the AA checked medications but did not compare the FSBS results documented on the eMAR with the FSBS readings recorded in the glucometer histories. Attempted interview with Resident #5's primary care provider (PCP) on 09/29/21 at 2:54pm was unsuccessful. b. Review of Resident #5's physician's orders revealed there was an order dated 09/20/21 for	D 358	• THE AA WILL CHECK AT LEAST ONCE A WEEK: ~~THAT~~ FSBS RESULTS RECORDED ON eMAR AND ONE ON EACH RESIDENT'S GLUCOMETETER ARE THE SAME • AA WILL CHECK THE eMAR DOCUMENTATION OF BS READINGS AND INSULIN GIVEN FOR ACCURACY.	11/8/21 10/1/21

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D 358	Continued From page 7 Novolog sliding scale insulin (SSI) four times daily with parameters as follows: 201-250= 2 units; 251-300= 4 units; 301-350= 6 units; 351-400= 8 units; and 401-450= 10 units; and greater than 450 call physician. Review of Resident #5's September 2021 eMAR revealed: -There was an entry for Novolog SSI four times daily with parameters: 201-250= 2 units; 251-300= 4 units; 301-350= 6 units; 351-400= 8 units; and 401-450= 10 units; and greater than 450 call physician scheduled for administration at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was an entry for FSBS scheduled daily at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There were 36 opportunities for FSBS to be checked and Novolog SSI administered from 09/20/21 through 09/29/21. -There were no documented FSBS results on the following dates: 09/20/21 at 5:00pm, 09/20/21 at 8:00pm, 09/21/21 at 8:00am, 09/21/21 at 12:00pm, 09/21/21 at 5:00pm, 09/22/21 at 12:00pm, 09/22/21 at 5:00pm, 09/23/21 at 8:00am, 09/22/21 at 12:00pm, 09/27/21 at 8:00am, 09/27/21 at 12:00pm, and 09/28/21 at 12:00pm and no insulin administered as ordered. -There was no reason why FSBS were not obtained and Novolog not administered. -Without documented FSBS it could not be determined if Resident #5's blood sugar was within range to administer Novolog SSI. -There were 24 documented FSBS results on the eMAR from 09/20/21 through 09/29/21. -There was documentation 8 of 24 FSBS results were within range to administer Novolog SSI. -There was no documentation Novolog SSI was administered as ordered as follows: -On 09/24/21 at 8:00am, FSBS-248, 0 units was documented as administered, and should have	D 358	• ALL MAS, AA & ADMINISTRATOR SUCCESSFULLY COMPLETED AN IN PERSON [redacted] TRAINING: "TRAINING ON CARE OF RESIDENT WITH DIABETES".	10/20/21

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D 358	Continued From page 8 been 2 units. -On 09/24/21 at 12:00pm, FSBS-250, 0 units was documented as administered, and should have been 2 units. -On 09/25/21 at 8:00am FSBS-314, 0 units was documented as administered, and should have been 6 units. -On 09/25/21 at 12:00pm FSBS-214, 0 units was documented as administered, and should have been 2 units. -On 09/26/21 at 8:00am FSBS-264, 0 units was documented as administered, and should have been 4 units. -On 09/26/21 at 12:00pm FSBS-301, 0 units was documented as administered, and should have been 6 units. -On 09/26/21 at 5:00pm FSBS-301, 0 units was documented as administered, and should have been 6 units. -On 09/26/21 at 8:00pm FSBS-260, 0 units was documented as administered, and should have been 4 units. Interview with Resident #5 on 09/30/21 at 12:20pm revealed: -His FSBS were checked by the MA three times daily. -The MA told him the FSBS result, but he did not remember. -He was aware that he was ordered a SSI two weeks ago but was not aware of the parameters of the SSI. -Sometimes after checking his FSBS the MA administered insulin, but she did not tell him the units of insulin administered. Interview with the MA on 09/29/21 at 10:59am revealed: -It was the facility's policy for her to document the units of SSI administered.	D 358		

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D 358	Continued From page 9 -She was unable to explain why she did not document the units of SSI administered to Resident #5. -She was aware without documentation it could not be determined if she administered Resident #5's Novolog SSI and the units of SSI administered. -The Assistant Administrator (AA) checked the eMARs daily and was supposed to make corrections on the eMAR. Interview with the AA on 09/29/21 at 11:05am revealed: -He checked the eMARs daily to ensure medications were administered. -He did not realize the MA was not documenting the units of SSI administered. Interview with the Administrator on 09/29/21 at 11:10am revealed: -The AA was responsible for checking the eMARs to ensure medications were administered correctly. -The AA should have identified the MA was not documenting when she administered SSI. -He was aware without documentation it could not be determined how much SSI was administered Resident #5. Attempted interview with Resident #5's PCP on 09/29/21 at 2:54pm was unsuccessful.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the	D 366		

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D 366	Continued From page 10 staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication aides observed residents taking their medication for 1 of 5 residents sampled (#2) including observation of a resident's medication left at bedside. The findings are: Review of Resident #2's current FL2 dated 01/26/21 revealed: - Diagnoses included heart disease, hypertension arthritis, back, hip and knee pain. -There was an order for Amitiza 24mcg capsule take one two times a day. (Used to treat irritable bowel syndrome.) -There was an order for aspirin EC 81mg tablet take one every day. (Used to thin the blood) -There was an order for oxycodone-acetaminophen 10-325mg tablet take one every 4 hours. (Used to treat moderate pain.) -There was an order for metoprolol tartrate 25mg take 2 tablets every morning. (Used to treat hypertension.) Observation of Resident #2's room on 09/28/21 at 09:40am revealed there was one yellow and one smaller white tablet and a pink capsule inside a plastic medication cup and one smaller yellow tablet inside a second plastic medication cup in the opened drawer of Resident #2's bedside table.	D 366	• ADMINISTRATOR HAS ASKED ALL AA STAFF TO WATCH RESIDENTS TAKE THEIR MEDICINE AND CHART ACCORDINGLY • AA WILL WATCH MED-PASSES AT LEAST ONCE A MONTH TO SEE THAT STAFF CORRECTLY ADMINISTER MEDICINE	09/30/21 11/8/21

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D 366	Continued From page 11 Interview with Resident #2 on 09/28/2021 at 09:45am revealed: -The bedside table and medications were his. -They were over the counter medications he kept in his room. -His primary care provider (PCP) knew he kept and took over the counter medications. Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Amitiza 24mcg capsule take one two times a day at 8:00am and documented as administered on 09/28/21 at 8:00am. -There was an entry for aspirin EC 81mg tablet take one every day at 8:00am and documented as administered on 09/28/21 at 8:00am. -There was an entry for oxycodone-acetaminophen 10-325mg tablet take one every 4 hours at 6:00am and 10:00am and documented as administered on 09/28/21 at 6:00am and 10:00am. -There was an entry for metoprolol tartrate 25mg take 2 tablets every morning at 8:00am and documented as administered on 09/28/21 at 8:00am. Interview with the MA on 09/28/19 at 9:50am revealed: -She did not know Resident #2 had medication in his bedside table. -She knew she was supposed to watch the residents take their medication before starting another resident's medications. -She watched him put the pills in his mouth during the morning medication pass. -She thought Resident #2 took his medications	D 366	• ADMINISTRATOR HAS SCHEDULED A MEDICATION ADMINISTRATION CLASS ON 11/11/2021 BY AN RN FOR ALL MEDICATION ADMINISTRATION STAFF.	11/11/21

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D 366	Continued From page 12 she gave him that morning. Review of Resident #2's medications on hand 09/28/2021 revealed: - There was a pink capsule labeled Amitiza 24mcg capsule take one two times a day with 6 of 60 capsules remaining. -There was a small yellow tablet labeled aspirin EC 81mg tablet take one every day with 5 of 30 tablets remaining. -There was a larger yellow tablet labeled oxycodone-acetaminophen 10-325mg tablet take one every 4 hours with 5 of 30 tablets remaining. -There was a small white tablet labeled metoprolol tartrate 25mg take 2 tablets every morning with 5 of 30 tablets remaining. Interview with Resident #2 on 09/29/21 at 9:55am revealed: -The MA gave his medications to him in a plastic cup and gave him water but the MA did not watch him take his medications. -The MA did not ask him if he had taken his medication. -The MA sat his medications on his bedside table that morning and left the room. -He did not feel like taking all of his medications right then and so he took some and left others in the medication cup and put them in his drawer. -He was going to take his medications after breakfast. -He did not save his medications all the time, that morning was the only time. -He had not felt extra sleepy or like his blood pressure or heart rate were low or high. Interview with the Administrator on 09/28/21 at 10:05am revealed: -He was responsible for monitoring the MAs. -He expected all medications to be administered	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032073	A. BUILDING: _____ B. WING _____	R 09/30/2021

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D 366	Continued From page 13 as ordered. -The MAs had been trained to watch the residents take their medications and document on the eMARs after administration and before starting on another resident's medications. -It was the facility's policy to watch each resident take their medications and not to leave medications at the bedside. Telephone interview with a nurse from Resident #2's PCP's office on 09/20/21 at 4:50pm revealed: -Resident #2 was not assessed to keep medications at the bedside. -The PCP expected the staff to watch him take his medications. -There had been no reports from the facility of Resident #2 attempting to save or cheek medications. -If the tablets were metoprolol or oxycodone-acetaminophen, taking a dose later closer to the next dose or missing a dose could result in a slow or fast heart rate, high or low blood pressure or being sleepy.	D 366		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:	D935 →	• STAFF C IS NOT ADMINISTERING MEDICATIONS ANYMORE AND HAS SCHEDULED TO TAKE THE MEDICATION AIDE EXAM ON 11/8/2021 as of 9/30/21	

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D935	Continued From page 14 (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 staff sampled (Staff C) who administered medications had passed the written medication aide exam within 60 days of completing the medication clinical skills evaluation. The findings are:	D935	The Administrator and/or AA will check employee records monthly to ensure the required training and documents are in the records. per telephone call 11/05/21.	11/08/21

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D935	Continued From page 15 Review of Staff C's, medication aide (MA) personnel record revealed: -Staff C was hired on 01/05/21. -There was a certificate of completion dated 04/10/21 for the 15-hour state approved medication aide training. -There was documentation of a medication clinical skills competency validation checklist dated 04/10/21. -There was no documentation Staff C had successfully passed the written medication aide exam. Review of residents' medication administration records (MARs) revealed at various times Staff C documented administration of medication administered for 10 days in July 2021, 11 days in August 2021 and 12 days in September 2021 including insulin administration. Attempted telephone interview with Staff C on 09/29/21 at 4:25pm and 09/30/21 at 9:15am was unsuccessful. Interview with the Administrator on 09/29/21 at 3:15pm revealed: -Staff C was hired in January 2021 in the kitchen and began training for medication aide in April 2021. -Staff C completed the 15-hour medication aide training in April 2021 with the facility nurse. -Staff C completed the medication clinical skills competency in April 2021. -Staff C's 60-days from date of hire as an MA was June 2021. -Staff C had not taken the written medication aide exam. -He had attempted to schedule Staff C for the written medication aide exam from April 2021 until July 2021, but the test sites were full for all dates.	D935		

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D935	Continued From page 16 -He had not attempted since July 2021 to schedule Staff C for the written medication aide exam. -Staff C continued to work as a MA administering medications to the residents because the facility was short staffed.	D935		