Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008041	A. BUILDING: _____ B. WING _____	R 01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

(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 Bertie County Department of Social Services conducted a follow-up survey on 01/19/22.	{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: FOLLOW-UP TO TYPE B VIOLATION THE TYPE B VIOLATION WAS ABATED. NON COMPLIANCE CONTINUES Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents sampled (#1 and #2) for sliding scale insulin (#1), a scheduled medication for treatment of anxiety and a medication to be administered as needed for anxiety (#2). The findings are: 1. Review of Resident #1's current FL-2 dated 12/14/21 revealed: -Diagnoses included type 2 diabetes. -There was an order for Humulin-R sliding scale, three times a day before meals with instructions if blood sugar was between 201-250 administer 5 units, 251-300 administer 10 units, 301-350	{D 358}	Medication class will be completed 3/11/22 with medication aides. Staff will also received training on the insulin pens on 3/11/22. Staff will be refreshed on all diabetic procedures and documentation. Staff also will be refreshed on following exact physician orders.	3/11/22

Division of Health Service Regulation
LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Debra Edwards — a Demonstrator — 2-22-22

STATE FORM 6899 W7RY12 If continuation sheet 1 of 12

Received & Acknowledged 02/22/22
M Bennett RN

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{D 358}	Continued From page 1 administer 15 units, 351-400 administer 20 units (Humulin is a short acting insulin used to manage blood sugars in diabetics). Review of Resident #1's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Humulin-R with instructions to check blood sugar three times a day before meals and administer insulin per the sliding scale: 201-250= 5 units, 251-300= 10 units, 301-350= 15 units, 351-400= 20 units, scheduled for administration at 7:30am, 11:30am, and 5:30pm. -On 12/20/21 at 7:30am, her blood sugar was 266 and Humulin-R 15 units was documented as administered, when 10 units was ordered. -On 12/20/21 at 11:30am, her blood sugar was 288 and Humulin-R 5 units was documented as administered, when 10 units was ordered. Review of Resident #1's January 2022 eMAR revealed: -There was an entry for Humulin-R with instructions to check blood sugar three times a day before meals and administer insulin per the sliding scale: 201-250= 5 units, 251-300= 10 units, 301-350= 15 units, 351-400= 20 units, scheduled for administration at 7:30am, 11:30am, and 5:30pm. -On 01/04/22 at 11:30am, her blood sugar was 360 and Humulin-R 25 units was documented as administered, when 20 units was ordered. Interview with Resident #1 on 01/19/22 at 1:40pm revealed the medication aides (MA) administered her insulin and she was not sure how many units she received. Telephone interview with Resident #1's primary	{D 358}		

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{D 358}	Continued From page 2 care provider's (PCP) nurse on 01/19/22 at 1:30pm revealed: -Resident #1 was ordered sliding scale insulin to treat her type 2 diabetes. -She expected that Resident #1 received the ordered amount of insulin based on her blood sugar. -Resident #1 was at risk for falls if her blood sugar was too low, which was a possibility if she received the incorrect amount of insulin. Interview with the Administrator on 01/19/22 at 2:00pm revealed: -She expected Resident #1 to receive her sliding scale insulin as ordered. -She removed the lead MA that administered Resident #1's insulin on 12/20/21 and 01/04/22 from the medication cart because of multiple errors previously identified. -The lead MA was responsible for completing eMAR audits weekly. -The lead MA was now going to be responsible for resident transport and personal care aide duties. -If Resident #1 received the wrong amount of insulin she might be at risk for hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). Attempted interview with the lead MA on 01/19/22 at 1:55pm that administered Resident #1's insulin on 12/20/21 and 01/04/22 was unsuccessful. 2.Review of Resident #2's current FL-2 dated 06/14/21 revealed diagnoses included moderate intellectual disability, depression and anxiety. a.Review of Resident #2's physician's order dated 01/01/22 revealed there was an order for Clonazepam 1mg to be administered every 12 hours for anxiety.	{D 358}		

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{D 358}	Continued From page 3 Review of Resident #2's January 2022 electronic medical record (eMAR) revealed: -There was an entry for Clonazepam 1 mg to be administered each day at 8:00am and 8:00pm. -There was documentation of administration at 8:00am each day on 01/01/22 through 01/19/22. -There was documentation of administration at 8:00pm on 01/01/22 through 01/18/22. Review of Resident #2's controlled medication log for Clonazepam 1mg revealed: -There were 3 doses signed for administration of 3 doses that did not indicate a date or time prior to 01/15/22. -There was documentation of administration on 01/15/22 at 8:00pm. -There was documentation of administration on 01/16/22 at 8:00am. -There was a second entry for documentation on administration on 01/15/22 at 8:00pm. -There was documentation of administration on 01/17/22 at 8:00pm. -There was documentation of administration on 01/18/22 at 8:00am and 8:00pm. -There was documentation of administration on 01/19/22 at 8:00am. -There was no documentation of administration from 01/01/22 through 01/14/22. Review of a second controlled medication log for Clonazepam 1mg revealed: -There was documentation of administration on 01/17/22 at 8:00am. -There was no documentation of administration for any other date or time. The facility did not provide any other controlled medication logs for Clonazepam 1mg requested on 01/19/22.	{D 358}		

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{D 358}	Continued From page 4 b.Review of Resident #2's physician's order dated 10/01/21 revealed an order for Clonazepam 0.5mg take 2 tablets each day as needed for anxiety. Review of Resident #2's December 2021 electronic medical record (eMAR) revealed: -There was an entry for Clonazepam 0.5mg, take 2 tablets each day as needed for anxiety/agitation. -There was documentation of administration on 12/04/21 at 7:02pm. -There was documentation of administration on 12/11/21 at 10:21am. Review of Resident #2's controlled medication log for Clonazepam 0.5mg revealed: -The instruction stated to administer 2 tablets per PCP order dated 10/01/21. -There was documentation of administration of 1 tablet given on 12/10/21 at 8:00am. -There was documentation of administration of 1 tablet given on 12/11/21 at 10:00am. -There was documentation of administration of 1 tablet given on 12/14/21 at 8:00am. -There was documentation of administration of 1 tablet given on 12/18/21 at 8:00pm. -There was no documentation of administration on 12/04/21. Review of Resident #2's January 2022 eMAR revealed: -There was an entry for Clonazepam 0.5mg, take 2 tablets each day as needed for anxiety/agitation. -There was documentation of administration on 01/08/22. Review of Resident #2's controlled medication log	{D 358}		

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{D 358}	Continued From page 5 for Clonazepam 0.5mg revealed: -There was documentation of administration of 1 tablet given on 01/01/22 at 8:00pm. -There was documentation of administration of 2 tablet given on 01/08/22 at 7:00pm. Interview with a medication aide (MA) on 01/19/22 at 2:19pm revealed: -MA's perform a controlled medication count at the change of each shift to ensure the controlled medication count matches the controlled medication logs. -Some MA's may be clicking the computer too fast and document administration of medications that had not been administered. -MA's may have forgotten to document some controlled medication that were administered on the computer. Interview with the Administrator on 01/19/22 at 2:30pm revealed: -She expected MA's to document each administration of medications on the computerized MAR at the time of administration. -She expected each of dose of controlled medications to be signed out on the controlled logs at the time the medication is pulled from the count. -MA's were expected to count controlled medications and compare to the logs at the change of shift.	{D 358}	Manager to check control count sheets weekly to ensure documentation is accurate and complete. Administrator will follow monthly. Administrator has completed meetings with all staff on the control records for completeness and accuracy and the importance of slowing down on 1/28/2022.	1/28/22
{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:	{D 367}		

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{D 367}	Continued From page 6 (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 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 interviews and record reviews, the facility failed to ensure medication administration records were complete and accurate for 2 of 3 residents sampled including medications for hypothyroidism (Resident #1) and medications to be administered as need to control pain and anxiety (Resident #2). 1.Review of Resident #2's current FL-2 dated 06/14/21 revealed diagnoses included moderate intellectual disability, depression and anxiety. a.Review of Resident #2's physician's order dated 10/01/21 revealed an order for Clonazepam 0.5mg take 2 tablets each day as needed for anxiety. Review of Resident #2's electronic medical record (eMAR) for December 2021 revealed: -There was an entry for Clonazepam 0.5mg, take	{D 367}	medication aides will complete a medication review class on 3/11/22. this will include emar documentation and control sheet documentation. Manager will check emars weekly to control sheets weekly to ensure proper documentation and administrator will review emars and controls monthly or as needed before. Class will be completed by Akia Brown RN with Express Care Pharmacy. Administrator will ensure this is mandatory for all staff.	3/11/22

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{D 367}	Continued From page 7 2 tablets each day as needed for anxiety/agitation. -There was documentation of administration on 12/04/21 and 12/11/21. Review of Resident #2's controlled medication log for Clonazepam 0.5mg revealed: -There was documentation of administration of 1 tablet given on 12/10/21 at 8:00am. -There was documentation of administration of 1 tablet given on 12/11/21 at 10:00am. -There was documentation of administration of 1 tablet given on 12/14/21 at 8:00am. -There was documentation of administration of 1 tablet given on 12/18/21 at 8:00pm. -There was no documentation of administration on 12/04/21. Review of Resident #2's eMAR for January 2022 revealed: -There was an entry for Clonazepam 0.5mg, take 2 tablets each day as needed for anxiety/agitation. -There was documentation of administration on 01/08/22. Review of Resident #2's controlled medication log for Clonazepam 0.5mg revealed: -There was documentation of administration of 1 tablet given on 01/01/22 at 8:00pm. -There was documentation of administration of 2 tablet given on 01/08/22 at 7:00pm. b.Review of Resident #2's physician order dated 12/02/21 revealed an order for Hydrocodone-Acetaminophen 7.5-325mg one tablet to be administered every six hours as needed for pain. Review of Resident #2's electronic medical	{D 367}		

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{D 367}	Continued From page 8 record (eMAR) for December 2021 revealed: -There was an entry for Hydrocodone-Acetaminophen 7.5-325mg one tablet to be administered every six hours as needed for pain. -There was documentation of administration on 12/03/21. -There was documentation of administration twice on 12/04/21 and 12/08/21. -There was documentation of administration on 12/11/21 and 12/12/21. Review of Resident #2's controlled medication log for Hydrocodone-Acetaminophen 7.5-325mg revealed: -There was documentation of administration of 1 tablet on 12/03/21 at 8:00pm. -There was documentation of administration of 1 tablet on 12/04/21 at 1:12pm and 8:00pm. -There was documentation of administration of 1 tablet on 12/05/21 at 12:00pm. -There was documentation of administration of 1 tablet on 12/07/21 at 8:00am and 6:00pm. -There was documentation of administration of 1 tablet on 12/08/21 at 7:00pm. -There was documentation of administration of 1 tablet on 12/09/21 at 8:00am. -There was documentation of administration of 1 tablet on 12/11/21 at 8:00am. -There was documentation of administration of 1 tablet on 12/13/21 at 8:00am and 8:00pm -There was documentation of administration of 1 tablet on 12/15/21 at 8:00pm. -There was documentation of administration of 1 tablet on 12/16/21 at 8:00am. -There was documentation of administration of 1 tablet on 12/18/21 at 8:00pm. -There was documentation of administration of 1 tablet on 12/31/21 at 8:00pm.	{D 367}		

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{D 367}	Continued From page 9 Interview with a medication aide (MA) on 01/19/22 at 2:19pm revealed: -MA's perform a controlled medication count at the change of each shift to ensure the controlled medication count matches the controlled medication logs. -Some MA's may be clicking the computer too fast and document administration of medications that had not been administered. -MA's may have forgotten to document some controlled medication that were administered on the computer. Interview with the Administrator on 01/19/22 at 2:30pm revealed: -She expected MA's to document each administration of medications on the computerized MAR at the time of administration. -She expected each of dose of controlled medications to be signed out on the controlled logs at the time the medication is pulled from the count. -MA's were expected to count controlled medications and compare to the logs at the change of shift. 2. Review of Resident #1's current FL-2 dated 12/14/21 revealed: -Diagnoses included hypothyroidism. -There was an order for Levothyroxine 100 mcg, 1 tablet daily before breakfast (Levothyroxine is a medication used to treat hypothyroidism). Review of Resident #1's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Levothyroxine 100mcg, take 1 tablet once daily before breakfast, scheduled for administration at 6:00am. -Levothyroxine 100mcg was not documented as	{D 367}		

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{D 367}	Continued From page 10 administered on 11/04/21, 11/09/21, 11/10/21, 11/11/21, 11/15/21, 11/22/21, 11/25/21, and 11/29/21. -There were 8 doses out of 30 that were not documented as administered. Review of Resident #1's December 2021 eMAR revealed: -There was an entry for Levothyroxine 100mcg, take 1 tablet once daily before breakfast, scheduled for administration at 6:00am. -Levothyroxine 100mcg was not documented as administered on 12/01/21, 12/04/21, 12/07/21, 12/08/21, 12/09/21, 12/15/21, 12/18/21, 12/19/21, 12/22/21, 12/23/21, and 12/28/21. -There were 11 doses out of 31 that were not documented as administered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/19/22 at 11:15am revealed: -Levothyroxine 100mcg was dispensed to the facility on 11/09/21, 12/09/21, and 01/11/22 for one-month supplies. -The facility was on batch-cycle autofill so the blister pack would be sent a week prior to starting the medication. Observation of Resident #1's medications on hand on 01/19/21 at 11:30am revealed Levothyroxine 100mcg had a blister pack started on 01/18/21. Interview with Resident #1 on 01/19/22 at 11:40am revealed she recalled taking medications before breakfast but was not sure if it was her Levothyroxine. Interview with a medication aide (MA) on 01/19/21 at 1:46am revealed:	{D 367}		

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{D 367}	Continued From page 11 -There was sometimes no MA on third shift, so first shift administered Resident #1's Levothyroxine at 7:00am. -Since the medication was ordered on the previous shift there was no way to document the medication, therefore it was left blank on the eMAR even though the medication was administered. Telephone interview with Resident #1's primary care provider's (PCP) nurse on 01/19/22 at 1:30pm revealed it was expected that the eMAR was accurate and complete because the PCP referred to the documentation to adjust dosages and refers to the eMAR for effectiveness of medications ordered. Interview with the Administrator on 01/19/22 at 2:00pm revealed: -The lead MA was responsible for completing eMAR audits weekly. -She was not aware that Resident #1's Levothyroxine was not being documented as administered when the first shift administered the medication. -She would check with the computer system company to see why the medication was not showing overdue on the first shift if it was not given on third shift. -She expected eMAR to be complete and accurate.	{D 367}		