Received via email on 09/06/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079089	A. BUILDING: _____ B. WING _____	R 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN # 2	187 GLENDALE DRIVE EDEN, NC 27288

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 06/29/22.	C 000	Om 6/29/22 a review was done with the med staff to ensure that the proper recording and administration of insulin was being done. A large copy of the administration paramaters was placed in the resident chart, MARs and on the inside of the medication administration closet. The administrator reviewed the proper administration and documentation for Resident. Residents sugar remain under control without the administration of insulin. Additionally, staff underwent a renewed course on diabetes 101 on 7/6/2022 and the annual 6 ceu requirement on medication administration on 7/16/22. This training included medical documentation as well as administration. Additionally, in house physicians have reviewed the records of resident and have found no ill effects to said resident. The administrator or designee will review resident chart twice a week to insure proper administration and documentation of insulin. In addition pharmacy and physician reviews will continue to occur quarterly and semi annually as an additional verification tool.	07/16/22
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 ensure medications were administered as ordered and by the Primary Care Provider (PCP) for 1 of 3 sampled residents (#1) including errors with obtaining finger stick blood sugars (FSBS) and administration of sliding scale insulin. The findings are: Review of the facility's policy and procedures on Medication Administration revealed: -All medications and treatments will be administered according to this policy and procedure and NC Adult Care Homes medication administration training curriculum. -When medication administration has been assigned to Safe Haven as stated in the Coordinated Service and Support Plan and/or Addendum, staff who will set up or administer medications to persons served will receive	C 330		

Reviewed and Acknowledged 09/06/22 KHH

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C 330	Continued From page 1	C 330		

training and demonstrate competency as well as reviewing this policy and procedure.
-Medication setup means the arranging of medications according to instructions from the pharmacy, the prescriber, or a licensed nurse, for administration.
-Staff will document the following information in the person's served medication administration record:
1. Dates of medication administration.
2. Name of medication.
3. Quantity of dose.
4. Times to be administered.
5. Route of administration at the time of set up.
6. When the person will be away from the service location
7. To whom the medication was given.

Review of Resident #1's current FL2 dated 10/22/21 revealed:
-Diagnoses included hypertensive heart disease, chronic kidney disease, anorexia, hypercalcemia and osteoarthritis.
-There was an order for Humalog with notation "per sliding scale" with no parameters (short acting insulin used to control diabetes).
-There was an order for fingerstick blood sugars (FSBS) three times daily with meals.

Review of Resident #1's physician's orders dated 10/28/22 revealed an order for Novolog sliding scale three times a day with meals that included the following parameters: 150-200= 2 units; 201-250=4 units; 251-300= 6 units; 301-350= 8 units; 351-400= 10 units; less than 60 or greater than 400 call the primary care provider (PCP).

Review of Resident #1's April 2022 medication administration record (MAR) revealed:
-There was an entry for FSBS and Novolog

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C 330	Continued From page 2 sliding scale insulin three times daily before meals scheduled at 8:00am, 12:00pm and 5:00pm. -There was documentation Resident #1's FSBS were checked three times daily before meals from 04/01/22 through 04/30/22. -There were 51 documented opportunities when Resident #1's FSBS was within range to be administered Novolog sliding scale insulin. -There were 19 of the 51 opportunities when the incorrect units of insulin were documented as administered, insulin was documented as administered with no corresponding FSBS and there were 2 incidents when "err" was documented on the MAR with no FSBS and no units of insulin administered as follows: -On 04/01/22 at 8:00am, FSBS was 310, 4 units of insulin administered and should have administered 8 units. -On 04/03/22 at 8:00am, "err" was documented; there was no FSBS documented, no units of insulin documented as administered and there was no reason why "err" was documented. -On 04/04/22 at 8:00, "err" was documented; there was no FSBS documented, no units of insulin documented as administered and there was no reason why "err" was documented. -On 04/04/22 at 12:00pm, FSBS was 274, 4 units of insulin documented as administered and should have administered 6 units. -On 04/07/22 at 8:00am, FSBS was 133, 2 units of insulin documented as administered and no insulin should have been administered. -On 04/07/22 at 12:00pm, FSBS was 282, 4 units of insulin documented as administered and should have administered 6 units. -On 04/13/22 at 8:00am, FSBS was 161, no insulin was documented as administered and should have administered 2 units. -On 04/13/22 at 12:00pm, FSBS was 269, 4 units	C 330		

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C 330	Continued From page 3 of insulin was documented as administered and should have administered 6 units. -On 04/13/22 at 5:00pm, FSBS was 189, no insulin was documented as administered and should have administered 2 units. -On 04/15/22 at 12:00pm, FSBS, was 276, 4 units of insulin was documented as administered and should have administered 6 units. -On 04/18/22 at 8:00pm, no FSBS was documented, 4 units of insulin was documented as administered. Without an FSBS, it could not be determined the correct units of insulin that should have been administered. -On 04/20/22 at 8:00pm, no FSBS was documented, 4 units of insulin was documented as administered. Without an FSBS, it could not be determined the correct units of insulin that should have been administered. -On 04/24/22 at 12:00pm, FSBS was 276, 4 units of insulin was documented as administered and should have administered 6 units. -On 04/24/22 at 8:00pm, no FSBS was documented, 4 units of insulin was documented as administered. Without an FSBS it could not be determined the correct units of insulin that should have been administered. -On 04/25/22 at 8:00am, FSBS was 120, 6 units of insulin was documented as administered and no insulin should have been administered. -On 04/26/22 at 12:00pm, FSBS was 258, 4 units of insulin was documented as administered and should have administered 6 units. -On 04/26/22 at 8:00pm, no FSBS was documented, 4 units of insulin was documented as administered. Without an FSBS it could not be determined the correct units of insulin that should have been administered. -On 04/27/22 at 5:00pm, FSBS was 372, 6 units of insulin was documented as administered and should have administered 10 units.	C 330		

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C 330	Continued From page 4 -On 04/28/22 at 12:00pm, FSBS was 250, 2 units of insulin was documented as administered and should have administered 4 units. -Resident #1's blood sugar ranged between 88 and 374 from 04/01/22 through 04/30/22. Review of Resident #1's May 2022 MAR revealed: -There was an entry for FSBS and Novolog sliding scale insulin three times daily before meals scheduled at 8:00am, 12:00pm and 5:00pm. -There was documentation Resident #1's FSBS were checked three times daily before meals from 05/01/22 through 05/31/22. -There were 27 documented opportunities when Resident #1's FSBS was within range to be administered Novolog sliding scale insulin. -There were 8 of the 27 opportunities when the incorrect units of insulin were documented as administered, no FSBS or insulin was documented as administered and there 1 incident when "err" was documented on the MAR with no FSBS and no units of insulin administered as follows: -On 05/02/22 at 12:00pm, FSBS was 318, 6 units of insulin was documented as administered and should have administered 8 units. -On 05/02/22 at 5:00pm, no FSBS and no insulin was documented as administered. There was no explanation why the FSBS was not checked. -On 05/05/03/22 at 12:00pm, FSBS was 471, 10 units was documented as administered. There was no documentation the PCP was contacted as ordered to determine if more insulin was needed. -On 05/05/22 at 8:00am, "err" was documented. There was no documentation why the FSBS was not checked and insulin not administered as ordered. -On 05/05/22 at 12:00pm, FSBS was 247, 6 units	C 330		

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C 330	Continued From page 5 of insulin was documented as administered and should have administered 4 units. -On 05/06/22 at 12:00pm, FSBS was 251, 4 units of insulin was documented as administered and should have administered 6 units. -On 05/12/22 at 12:00pm, FSBS was 257, 4 units of insulin was documented as administered and should have administered 6 units. -On 05/20/22 at 5:00pm, no FSBS was documented and no insulin was documented as administered. There was no documentation as to why FSBS was not checked. -Resident #1's blood sugar ranged between 71 and 471 from 05/01/22 through 05/31/22. Review of Resident #1's June 2022 MAR revealed: -There was an entry for FSBS and Novolog sliding scale insulin three times daily before meals scheduled at 8:00am, 12:00pm and 5:00pm. -There was documentation Resident #1's FSBS were checked three times daily before meals from 06/01/22 through 06/29/22. -There were 18 documented opportunities when Resident #1's FSBS was within range to be administered Novolog sliding scale insulin. -There were 1 of the 18 opportunities when the incorrect units of insulin were documented as administered, no FSBS or insulin was documented administered and there one incident when "err" was documented on the MAR with no FSBS and no units of insulin administered as follows: -On 06/13/22 at 12:00pm FSBS was 274, 4 units documented administered, should have administered 6 units. -Resident #1's blood sugar ranged between 74 and 310 from 06/01/22 through 06/29/22.	C 330		

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C 330	Continued From page 6 Interview with the Supervisor-in-Charge (SIC) on 06/29/22 at 2:50pm revealed: -The facility did not have a system where someone went behind the medication aide (MA) to ensure units of insulin documented as administered to Resident #1 were in correspondence with the resident's order for Novolog sliding scale. -She had previously observed another SIC that was not sure how to document the FSBS and units of insulin. -She showed the staff how to document the FSBS and units of insulin administered, she did not check to ensure the units of insulin administered were accurate. -When she wrote "err" on the MAR, that meant she was unable to obtain a FSBS. -Most of the time, the glucometer gave an "err" message if there was not enough blood to get a blood sugar reading. -She did not obtain another FSBS because there was no order to do so. -She thought there were so many errors of insulin administration in April 2022 because staff did not write the FSBS down right away and they were forgetting to document the FSBS. Telephone interview with Resident #1's PCP on 06/29/22 at 1:29pm revealed: -Although Resident #1's FSBS had improved and was lower over the past several months, she still expected medication orders to be followed as written. -When in the facility, she did not check the MARs and was not aware Resident #1's insulin was not administered as ordered. Interview with the Assistant Administrator on 06/29/22 at 3:44pm revealed: -He was not aware the MAs did not administer	C 330		

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C 330	Continued From page 7 Resident #1's insulin correctly. -He expected staff to administer medications as ordered. -Currently, there was no system for checking the MARs behind the MAs to ensure sliding scale insulin was administered as ordered. Attempted telephone interview with the MA that documented the most errors on the MARs on 06/29/22 at 3:43pm was unsuccessful. Based on observation, record review and attempted interview on 06/29/22, it was determined Resident #1 was not interviewable.	C 330		