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	HAL080032	A. BUILDING: _____ B. WING _____	R 01/27/2023

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BETHAMY RETIREMENT CENTER	909 N SALISBULRY AVENUE SPENCER, NC 28159

(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 a follow-up survey from 01/25/23 to 01/27/23.	{D 000}		
{D 188}	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term,	{D 188}		

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{D 188}	Continued From page 1 "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure required staffing hours were met on first, second and third shifts based on a census of 33 to 35 residents for 3 of 21 shifts sampled from 12/25/22 to 12/31/22, and a census of 38 to 39 residents for 2 of 21 shifts sampled from 01/08/23 to 01/14/23. The findings are: Review of the facility's 2023 license revealed the facility had a capacity of 43 residents. Review of the facility census record from 12/25/22 to 12/31/22 revealed there was a census of 33 to 35 residents which would require a total of 16 aide hours for first and second shifts. Review of staff timecards from 12/25/22 to 12/31/22 on first shifts revealed: -On 12/25/22, there was a total of 8.75 hours of aide coverage with a shortage of 7.25 hours. -On 12/30/22, there was a total of 11.0 hours of aide coverage with a shortage of 5.0 hours. Review of staff timecards from 12/25/22 to 12/31/22 on second shifts revealed on 12/25/22, there was a total of 11.75 hours of aide coverage with a shortage of 4.25 hours.	{D 188}		

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{D 188}	Continued From page 2 Review of the facility census record from 01/08/23 to 01/14/23 revealed there was a census of 38 to 39 residents which would require 16 aide hours for first and third shifts, and 8 of the third shift hours could be counted from the supervisor's time on duty since the facility was sprinklered. Review of staff timecards from 01/08/23 to 01/14/23 on first shifts revealed on 01/12/23 there was a total 4.0 hours of aide coverage with a shortage of 12.0 hours. Review of staff timecards from 01/08/23 to 01/14/23 on third shifts revealed on 01/14/23 there was a total 0.75 hours of aide coverage with a shortage of 7.25 hours after accounting for the supervisor's 8 hours. Interview with a personal care aide (PCA) on 01/26/23 at 4:20pm revealed: -She worked on second shift from 3:00pm to 11:00pm. -There was supposed to be two PCAs and one medication aide (MA) per shift. -Sometimes she worked as the only PCA in the facility. -She thought she worked short a PCA twice per week and it had been ongoing for the previous couple of months. -There was always a MA/supervisor on duty each shift. -The schedulers were aware that the PCAs had been working short staffed. -The schedulers had the PCA schedule the way they wanted it and had not made changes to the schedule to alleviate the PCAs from working short.	{D 188}		

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{D 188}	Continued From page 3 Interview with a second PCA on 01/26/23 at 4:25pm revealed: -She had worked at the facility since the beginning of October 2022. -She usually worked with one other PCA and one MA. -There was always a MA on duty each shift. -She had never worked without a second PCA on duty since she began employment at the facility. -The Resident Care Coordinator (RCC) and the Administrator made the staff schedules, but the Administrator made the schedule for January 2023. Interview with a MA on 01/26/23 at 4:30pm revealed: -She thought there had been improvement to the staff schedule in the last few months. -She had to work double shifts sometimes to cover the schedule, but there was always a MA on duty. -Normally there were two PCAs and one MA on first and second shifts, and one PCA and one MA on third shift. -She had worked short one PCA before in the previous couple of months, but could not remember the date(s). -The Administrator made the January 2023 schedule, and she was not sure who made the schedule for December 2022. Interview with the Administrator on 01/26/23 at 5:00pm revealed: -The RCC had made the schedule for December 2022 and she made the master schedule for January 2023. -The RCC adjusted the December 2022 and January 2023 schedules to cover staff who had called in or had to miss work for other reasons. -If a PCA called in or they were short staffed	{D 188}		

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{D 188}	Continued From page 4 during a shift the MA/supervisor-in-charge (SIC) usually called her. -She had not been aware that there were shifts that were short PCA hours. Interview with the RCC on 01/26/23 at 5:15pm revealed: -She had made the schedule in December 2022 and made as-needed adjustments to the schedule the Administrator made in January 2023. -The MAs were the Supervisors for each shift. -She scheduled one MA and two PCAs per shift on first and second shifts, and one PCA and one MA on third shift. -If there were no PCAs available to work a shift, she scheduled a MA to work in the PCA role for that shift. -She had not been made aware there were shifts that were short PCA hours.	{D 188}		
D 238	10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs.	D 238		

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This Rule is not met as evidenced by:
Based on record reviews, and interviews, the facility failed to ensure a resident's FL2 included complete information with current medications for administration and was clarified by the primary care provider (PCP) for 1 of 5 sampled residents (#5).

The findings are:

Review of Resident #5's current FL2 dated 12/14/22 revealed:
-Diagnoses included paranoid schizophrenia, hypertension, hyperlipidemia, diabetes, bipolar and anxiety.
-There were no medications listed on the FL2.
-There was a handwritten note where the medications should be listed "see attached."
-There was no medication list attached.

Review of Resident #5's record revealed there was no medication orders in the record dated 12/14/22.

Interview with the Resident Care Coordinator (RCC) dated 01/25/22 at 11:33am revealed:
-She prepared the FL2 dated 12/14/22.
-When she prepared the FL2 she did not list the medications on the FL2 because she thought it was "okay" to attach to physician's order sheet (POS) dated 11/16/22 to the FL2.
-She did not know the POS dated 11/16/22 could not be used as the medication list for the FL2 dated 12/14/22.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/25/23 at 3:20pm revealed:

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D 238	Continued From page 6 -The pharmacy did not receive a copy of Resident #5's FL2 dated 12/14/22. -The pharmacy was providing medications based on the signed physician's orders dated 11/23/21 and any other medication orders that were sent over electronically by Resident #1's primary care providers (PCP). -The pharmacy was not provided the POS dated 11/16/22. Interview with the Administrator dated 01/26/23 at 4:51pm revealed: -The resident's FL2 should include the current medication list and if the POS was attached the dates should match the FL2. -She was not aware Resident #5's FL2 did not include a current list of medications.	D 238		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure follow up with the primary care provider (PCP) for blood sugar levels greater than written parameters for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL2 dated 12/14/22 revealed: -Diagnoses included diabetes mellitus, insulin	D 273		

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dependence, blindness, heart murmur, hypertension and schizophrenia.
-The resident was constantly disoriented.
-The resident was semi-ambulatory due to blindness.
-Medication orders included an order for Novolog flexpen inject 2-15 units into the skin, 15 minutes before meals (a fast acting insulin used to treat elevated blood sugar levels).
-There was no order for sliding scale insulin (SSI) with parameters.
-There was no order for fingerstick blood sugars (FSBS).

Review of Resident #3's previous physician's order sheet (POS) dated 11/16/22 revealed:
-There was an order for FSBS checks with breakfast, lunch, dinner and at bedtime.
-There was an order for Novolog flexpen, check FSBS before each meal and inject per SSI: 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; 401-500=15 units.
-There was no physician's order with parameters regarding the amount of insulin to be given for FSBS greater than 501.
-There was no documentation regarding contact with the resident's Primary Care Provider (PCP) regarding the amount of insulin that should be administered for FSBS greater than 501.

Review of Resident #3's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog SSI scheduled at 7:30am; 11:30am and 4:30pm.
-There was documentation Resident #3 had 13 of 90 opportunities when FSBS were greater than 501.
-There was documentation the PCP was

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contacted once, on 11/26/22 to inform the FSBS was 563. The instructions were to give cold beverages and check the FSBS every hour and keep the PCP informed.
-There was no documentation the FSBS was checked every hour or that the PCP had been informed.
-There was no documentation the PCP was contacted regarding the amount of insulin that should have been administered for the FSBS that were greater than 501 as follows:
-On 11/01/22 at 7:30am, FSBS was 523.
-On 11/02/22 at 11:30am, FSBS was 596.
-On 11/03/22 at 7:30am, FSBS was 525.
-On 11/04/22 at 11:30am, FSBS was 561.
-On 11/06/22 at 7:30am, FSBS was 593.
-On 11/09/22 at 11:30am, FSBS was 541.
-On 11/18/22 at 7:30am, FSBS was 508.
-On 11/18/22 at 4:30pm, FSBS was 537.
-On 11/18/22 at 7:30pm, FSBS was 537.
-On 11/22/22 at 7:30am, FSBS was 525.
-On 11/25/22 at 7:30am, FSBS was 538.
-On 11/28/22 at 11:30am, FSBS was 533.
-On 11/30/22 at 7:30am, FSBS was greater "000" (greater than 600 per medication aide interview).

Review of Resident #3's December 2022 eMAR revealed:
-There was an entry for Novolog SSI scheduled at 7:30am; 11:30am and 4:30pm.
-There was documentation Resident #3 had 11 of 93 opportunities when FSBS were greater than 501.
-There was documentation the PCP was contacted once, on 12/06/22 to inform the FSBS was greater than 500.
-The instructions were to give cold beverages and check the FSBS every hour.
-There was no documentation the FSBS was checked every hour.

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-There was no documentation the PCP was contacted regarding the amount of insulin that should have been administered for the FSBS that were greater than 501 as follows:
-On 12/01/22 at 11:30am FSBS was 537;
-On 12/02/22 at 7:30am FSBS was 585;
-On 12/06/22 at 11:30am FSBS was 559;
-On 12/06/22 at 7:30pm FSBS was 533;
-On 12/09/22 at 7:30am FSBS was 587;
-On 12/10/22 at 7:30am FSBS was 577;
-On 12/15/22 at 7:30am FSBS was 577;
-On 12/17/22 at 7:30am FSBS was 529;
-On 12/19/22 at 7:30am FSBS was 518;
-On 12/25/22 at 7:30am FSBS was 569;
-On 12/30/22 at 7:30am FSBS was 598.

Review of Resident #3's January 2023 eMAR revealed:
-There was an entry for Novolog SSI scheduled at 7:30am; 11:30am and 4:30pm.
-There was documentation Resident #3 had 5 of 75 opportunities when FSBS were greater than 501.
-There was no documentation the PCP was contacted regarding the amount of insulin that should have been administered.
-Examples of FSBS greater than 501 as follows:
-On 01/06/22 at 7:30pm FSBS was 598;
-On 01/17/22 at 7:30am FSBS was "000" (greater than 600);
-On 01/25/22 at 11:30am FSBS was 590;
-On 01/25/22 at 7:30am FSBS was 599;
-On 01/25/22 at 11:30pm FSBS was 599.

Interview with the second shift medication aide (MA) on 01/25/23 at 4:01pm revealed:
-She was aware Resident #3 did not have an order for FSBS greater than 501, so she gave 15 units of insulin, which was the amount ordered for FSBS 401-500.

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-Resident #3 often had FSBS that were greater than 501.
-The highest number that recorded in the resident's glucometer was 599.
-After 599 the glucometer reads "hi," meaning the resident's blood sugar was over 600.
-When the glucometer read "hi" she put "000" on the eMAR because the eMAR had to have a number.
-It was the facility's policy when a resident had high blood sugars, greater than 500 she tried to reach the PCP.
-There should be documentation when the PCP was notified.
-If she contacted the PCP there should be a triage note in the resident's record to show the PCP was contacted.
-If the PCP gave instructions to recheck the resident's FSBS or administer insulin she did not document that on the eMAR.
-Sometimes she documented the FSBS recheck and insulin in the progress notes, but she was not sure that was what she did for Resident #3's FSBS greater than 501.

Interview with a first shift MA on 01/26/23 at 11:30am revealed:
-She was aware Resident #3 did not have an order for FSBS greater than 501.
-She did not ask the PCP for an order for FSBS greater 501, the PCP was aware because he wrote the order for SSI.
-Resident #3 often had blood sugars greater than 501.
-When Resident #3's FSBS were greater than 501 she administered 15 units of insulin.
-It was the facility's policy when a resident's FSBS was greater than 500 to hold the resident's meal, then recheck the FSBS.
-She did not contact the resident's PCP each time

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the resident's FSBS was greater than 501, but she usually rechecked the FSBS.
-She did not document when she rechecked the FSBS.
-Resident #3 would have been administered 15 units of insulin for FSBS greater than 400 based on the SSI order (401-500), no more insulin would have been ordered unless told to do so by the PCP.
-The facility's policy was to notify the PCP when FSBS were greater 500 but that was not documented anywhere.

Interview with the Resident Care Coordinator on 01/26/23 at 3:40pm revealed:
-It was the facility's policy to contact the resident's PCP for FSBS greater than 500.
-The MA should document when the PCP was notified as well as instructions given by the PCP.
-The facility's policy was not in writing, the MA should follow the PCP orders.
-If there was no order for FSBS greater than 501, then the MA should contact the PCP and ask the PCP to provide an order.
-If the PCP did not provide an order for FSBS greater than 501, then the MA should contact the PCP for every FSBS greater than 501.
-The MA should document all contacts with the provider.

Interview with the Administrator on 01/26/23 at 4:51pm revealed:
-When Resident #3's FSBS were greater than 500 she expected the MA to contact the PCP and document instructions given by the PCP.
-If the FSBS were frequently greater than 501, the MA should ask the PCP to conference to let him know how often the FSBS was greater than 500, and the PCP should be asked for an order for coverage.

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D 273	Continued From page 12 Based on observation, record review and interviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's PCP on 01/25/22 at 3:25pm was unsuccessful. _____ The facility failed to notify the PCP regarding Resident #3's blood sugars greater 501 resulting in untreated episodes of hyperglycemia. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on January 26, 2023. THE CORRECTION DATE FOR THE TYPE B VIOLATION WILL NOT EXCEED, MARCH 17, 2023.	D 273		
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. The facility shall ensure that this verification or clarification is documented in the resident's	D 344		

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D 344	Continued From page 13	D 344		

record.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to clarify the medication order for 1 of 5 sampled residents (Resident #3) related to no parameters for sliding scale and orders for fingerstick blood sugar (FSBS).

The findings are:

Review of Resident #3's current FL2 dated 12/14/22 revealed:
-Diagnoses included diabetes mellitus, insulin dependence, blindness, heart murmur, hypertension and schizophrenia.

a. Resident #3's current FL2 included an order for Novolog flexpen inject 2-15 units into the skin, 15 minutes before meals (fast acting insulin to reduce blood sugar).
-There was no order for sliding scale insulin (SSI) with parameters.
-There was no order for fingerstick blood sugar (FSBS).

Review of Resident #3's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS scheduled at 7:30am, 11:30am, 4:30pm and 7:30pm.
-There was documentation FSBS were checked 113 out of 120 opportunities on the FL2.
-There was an entry for Novolog sliding scale insulin (SSI) scheduled for administration at 7:30am, 11:30am, and 4:30pm.
-There was documentation Novolog SSI was administered 66 of 90 opportunities with no SSI

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D 344	Continued From page 14 order. Review of Resident #3's December 2022 eMAR revealed: -There was an entry for FSBS scheduled at 7:30am, 11:30am, 4:30pm and 7:30pm. -There was documentation FSBS were checked 110 out of 124 opportunities on the FL2. -There was an entry for Novolog sliding scale insulin (SSI) scheduled for administration at 7:30am, 11:30am, and 4:30pm. -There was documentation Novolog SSI was administered 64 of 83 opportunities with no SSI order. Review of Resident #3's January 2023 eMAR revealed: -There was an entry for FSBS scheduled at 7:30am, 11:30am, 4:30pm and 7:30pm. -There was documentation FSBS were checked 100 out of 100 opportunities with no order on the FL2. -There was an entry for Novolog sliding scale insulin (SSI) scheduled for administration at 7:30am, 11:30am, and 4:30pm. -There was documentation Novolog SSI was administered 61 of 75 opportunities with no SSI order. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/25/23 at 3:20pm revealed: -The most recent order for SSI and FSBS four times daily for Resident #3 was dated 07/21/22. -If there was an order for SSI and FSBS after 07/21/22. -The pharmacy had not received the FL2 dated 12/14/22. -If the pharmacy had received the FL2 and there was no sliding scale order or FSBS order the	D 344		

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pharmacy would have clarified the order with the PCP.

Interview with the Resident Care Coordinator (RCC) on 01/25/23 at 11:33am revealed:
-She did not consider Resident #3's hospital FL2 a legitimate FL2.
-She had not clarified the FL2 with the PCP.
-She had prepared another FL2 dated 12/14/22 and had it signed by the PCP, but she did not update the FL2 with medication orders.

Refer to the interview with the Administrator dated 01/26/23 at 4:51pm.

b. Review of Resident #3's current hospital FL2 dated 12/14/22 revealed:
-There was an order for humalog 3 units every morning (rapid acting insulin used reduce blood sugar).
-There was an additional order for humalog 3 units with breakfast, 2 units with lunch and 2 units with dinner.

Observation of Resident #3's medications on hand on 01/26/23 at 11:44am revealed:
-Humalog was available for administration.
-Review of the administration instructions label on the humalog were to administer 3 units with breakfast.

Review of Resident #3's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for humalog 3 units scheduled daily at 8:00am, 12:00pm and 5:00pm.
-There was no entry for humalog 3 units every morning.

Review of Resident #3's December 2022 eMAR

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revealed:
-There was an entry for humalog 3 units scheduled daily at 8:00am, 12:00pm and 5:00pm.
-There was no entry for humalog 3 units every morning.

Review of Resident #3's January 2023 eMAR revealed:
-There was an entry for humalog 3 units scheduled daily at 8:00am, 12:00pm and 5:00pm.
-There was no entry for humalog 3 units every morning.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/25/23 at 3:20pm revealed:
-The pharmacy had not received the hospital FL2 dated 12/14/22 and was not aware there were two orders for humalog 3 units in the morning.
-The last order the pharmacy had for humalog was dated 07/21/22 and it was for 3 units with breakfast, 2 units with lunch and 2 units with dinner.
-If the pharmacy had received the FL2 and there were two orders for humalog the pharmacy would have clarified the order with the PCP.

Interview with the Resident Care Coordinator (RCC) on 01/25/23 at 11:33am revealed:
-She had not reviewed the hospital FL2 dated 12/14/22.
-She did not know there were two orders for humalog 3 units in the morning.
-She had not contacted Resident #3's PCP to clarify the hospital FL2 dated 12/14/22.

Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 1/25/23 at 3:25pm was unsuccessful.

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D 344	Continued From page 17 Based on observation, record review and interviews it was determined Resident #3 was not interviewable. Refer to the interview with the Administrator dated 01/26/23 at 4:51pm. _____ Interview with the Administrator on 01/26/23 at 4:51pm revealed: -When a resident came from the hospital with an FL2 and discharge summary report she would like staff to ensure all matched. -If there were changes to medications the PCP should be contacted to clarify the orders. -The FL2 should include orders that matched the same date.	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: Based on observations, record review and interviews, the facility failed to administer medication as ordered in accordance with the facility's policies and per the manufacturer's instructions for 1 of 5 sampled residents (#2) who was being administered insulin from an expired insulin pen.	{D 358}		

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{D 358}	Continued From page 18 The findings are: Review of Resident #2's current FL2 dated 06/24/22 revealed diagnoses included type 2 diabetes, intellectual disability, and chronic kidney disease. Review of Resident #2's signed physician order dated 07/01/22 revealed: -An order for fingerstick blood sugar (FSBS) checks with meals and at bedtime. -An order for Humalog insulin (a fast-acting insulin used to treat elevated blood sugar levels) sliding scale parameters as follows: FSBS 0-200 give 0 units, 201-250 give 1 unit, 251-300 give 2 units, 301-350 give 3 units, 351-400 give 4 units, 401-450 give 5 units, 451-500 give 6 units, or if FSBS was over 500 notify the primary care provider (PCP). Review of Humalog's manufacturer's instructions dated April 2020 revealed: -In-use insulin pens should be stored at room temperature. -Humalog insulin pens should be discarded after 28 days from being opened, even if the pen still had insulin remaining in it. Review of Resident #2's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog insulin, check FSBS before each meal and at bedtime and inject per sliding scale: 0-200 give 0 units, 201-250 give 1 unit, 251-300 give 2 units, 301-350 give 3 units, 351-400 give 4 units, 401-450 give 5 units, 451-500 give 6 units, or if FSBS was over 500 notify the PCP and scheduled at 7:30am, 11:30am, 4:30pm, and 8:00pm.	{D 358}		

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{D 358}	Continued From page 19 -There was documentation insulin was administered to Resident #2 nine times from 11/01/22 through 11/30/22. -Resident #2's FSBS values ranged from 64 to 245 from 11/01/22 through 11/30/22. Review of Resident #2's December 2022 eMAR revealed: -There was an entry for Humalog insulin, check FSBS before each meal and at bedtime and inject per sliding scale: 0-200 give 0 units, 201-250 give 1 unit, 251-300 give 2 units, 301-350 give 3 units, 351-400 give 4 units, 401-450 give 5 units, 451-500 give 6 units, or if FSBS was over 500 notify the PCP, scheduled at 7:30am, 11:30am, 4:30pm, and 8:00pm. -There was documentation insulin was administered to Resident #2 four times from 12/01/22 through 12/31/22. -Resident #2's FSBS values ranged from 78 to 270 from 12/01/22 through 12/31/22. Review of Resident #2's January 2023 eMAR revealed: -There was an entry for Humalog insulin, check FSBS before each meal and at bedtime and inject per sliding scale: 0-200 give 0 units, 201-250 give 1 unit, 251-300 give 2 units, 301-350 give 3 units, 351-400 give 4 units, 401-450 give 5 units, 451-500 give 6 units, or if FSBS was over 500 notify the PCP, scheduled at 7:30am, 11:30am, 4:30pm, and 8:00pm. -There was documentation insulin was administered to Resident #2 seven times from 01/01/23 through 01/25/23. -Resident #2's FSBS values ranged from 87 to 350 from 01/01/23 through 01/25/23. Observation of medication on hand for Resident #2 on 01/25/23 at 2:40pm revealed:	{D 358}		

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-There was one Humalog insulin pen in the medication cart for Resident #2 in a plastic bag.
-The insulin pen was labeled with Resident #2's name.
-There was a "date opened" sticker on the insulin pen with the date of 10/05/22 written on it.
-The expiration date on the insulin pen, if unopened, was 02/11/2025.
-There were 160 units of clear insulin visible through the window in the insulin pen.
-There were two unopened insulin pens in the refrigerator in the medication room with a dispensed date of 08/28/22.

Observation of an information sheet provided by the pharmacy hanging by the refrigerator in the medication room on 01/26/22 at 12:35pm revealed:
-There was documentation that Humalog insulin pens were to be stored in the refrigerator until opened, then stored at room temperature once opened.
-There was documentation that Humalog insulin pens were to be discarded 28 days after opening.

Observation of the medication cart audit book on 01/25/23 at 3:35pm revealed:
-There were written instructions for how to complete the medication cart audit.
-Each MA was responsible for a group of resident's medications during the monthly audit.
-The MA was to print the most recent physician's orders sheet and match the physician orders with the medications on the cart.
-There was a checklist of everything that should be looked at during the audit, including checking for expired medications and that all medications were labeled with an opened-on date.
-There was a physician's order sheet for Resident #2 for November 2022, December 2022 and

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{D 358}	Continued From page 21 January 2023 with checkmarks aside each medication listed. Telephone interview with a representative from the facility's contracted pharmacy on 01/25/23 at 3:10pm revealed: -They dispensed three Humalog insulin pens to the facility for Resident #2 on 08/29/22 and that was the most recent dispensed date. -Humalog insulin pens were supposed to be thrown away 28 days after opening them per the manufacturer's instructions. Interview with a MA on 01/25/23 at 3:30pm revealed: -She had administered Humalog insulin to Resident #2 in the past three months. -She forgot to check the opened date on the insulin pen before administering it. -She was not sure when insulin pens were supposed to be disposed of after opening, but thought it was between 28 and 45 days. -The MAs completed medication cart audits every month; each MA had a list of residents whose medications they were responsible for auditing. -To complete the medication cart audit, the MA printed out the most recent Physician Order sheet for each resident and verified each medication in the cart for matching orders. -They also checked medications for expiration dates, need to reorder medications that were getting low, and that all of the "as needed" medications were available. -Resident #2 was on her list of residents that she was responsible for auditing on the medication cart. -She had audited Resident #2's medications in November and December 2022, and in January 2023. -She put a checkmark next to each medication	{D 358}		

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{D 358}	Continued From page 22 listed on the physician's order sheet to indicate that she had checked that medication. -She had missed the date Resident #2's Humalog insulin pen had been opened because Resident #2 rarely needed to use the insulin. -Once the medication cart audit was completed the MAs placed the physician order sheet in the medication cart audit book. Interview with the Resident Care Coordinator (RCC) on 01/25/23 at 3:40pm revealed: -The MAs were responsible for discarding insulin pens within 28-45 days from the day they were opened depending on the type of insulin pen. -The MAs completed audits of the medication carts once a month. -During the medication cart audit the MAs were supposed to check for expired medications, quantity remaining of each medication and to refill any medications that were running low, and ensuring all medications on the cart had a current order. -She was supposed to go behind the MAs and double check their audits, but she had not done that consistently because she was busy with other tasks. -She thought Resident #2's Humalog insulin pen had likely been overlooked during the medication cart audit. Interview with a MA on 01/26/23 at 12:30pm revealed: -New insulin pens were placed in the refrigerator in the medication room until they were needed. -When a MA took an insulin pen from the refrigerator, they were expected to write the opened-on date on the pen. -They had been trained upon hire at the facility to dispose of opened insulin pens after 28 days.	{D 358}		

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{D 358}	Continued From page 23 Interview with the Administrator on 01/26/23 at 5:00pm revealed: -She was not aware Resident #2 had been receiving Humalog insulin from an insulin pen dated 10/05/22. -One of the MAs should have caught the outdated insulin pen within the last three months during any of the times they were administering it. -The MA who completed the medication cart audits should have caught the expired date on Resident #2's insulin pen. Attempted telephone interview with Resident #2's PCP on 01/25/23 at 3:25pm was unsuccessful.	{D 358}		
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: (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	D935		

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D935	Continued From page 24 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 2 of 3 sampled (Staff A and Staff B) who administered medications had validation of successfully taking and passing the written medication aide exam. The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was hired on 09/06/22. -Staff A had completed the 5-hour and 10-hour MA training course on 10/05/22. -Staff A completed the medication administration clinical skills competency validation checklist on 10/05/22. -There was no documentation of employment verification for Staff A. -There was no documentation Staff A had taken	D935		

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D935	Continued From page 25 or passed the written MA exam. Review of a resident's November and December 2022 and January 2023 electronic Medication Administration Records (eMAR) revealed: -From 11/01/22 through 11/30/22, Staff A documented the administration of medications 15 days. -From 12/01/22 through 12/31/22, Staff A documented the administration of medications 12 days. -From 01/01/23 through 01/25/23, Staff A documented the administration of medications 11 days. Interview with the Business Office Manager (BOM) on 01/26/23 at 5:03pm revealed: -She had not been at the facility long and was not sure of the documentation in staff personnel records. -She was still searching for Staff A's medication aide examination from the earlier request for the documentation. -She would continue to search for the document and forward it to the surveyor tomorrow morning on 01/27/23. Telephone interview with the Resident Care Coordinator (RCC) on 01/27/23 at 4:11pm revealed: -She was sure Staff A had taken and passed the medication aide examination. -She did not keep track of personnel records; that was the responsibility of the Business Office Manager (BOM). -She made sure the MAs completed the clinical skills competency validation checklist with MAs after they completed their 15-hour training. -Staff A functioned as a MA and passed medications to the residents.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080032	A. BUILDING: _____ B. WING _____	R 01/27/2023

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D935	Continued From page 26 Interview with the Administrator on 01/27/23 at 4:12pm revealed: -She was not aware the BOM had not sent validation that Staff A had passed the medication examination. -She would make sure the information was faxed as soon as possible. -The RCC was responsible for ensuring the MAs had the required training. A request was made on 01/26/23 at 2:30pm and at 5:23pm and on 01/27/23 at 4:11pm for Staff A's validation of passing the written MA exam, but not provided by exit on 01/27/23. Staff A was not available for interviews on 01/26/23 and 01/27/23. 2. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was hired on 08/29/22. -Staff B had completed the 5-hour MA training course on 09/05/22. -Staff B had completed the 10-hour MA training course on 09/22/22. -Staff B completed the medication administration clinical skills competency validation checklist on 09/22/22. -There was no documentation of employment verification for Staff B. -There was no documentation Staff B had taken or passed the written MA exam. Review of a resident's November and December 2022 and January 2023 electronic Medication Administration Records (eMAR) revealed: -From 11/01/22 through 11/30/22, Staff B documented the administration of medications 7 days.	D935		

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D935	Continued From page 27 -From 12/01/22 through 12/31/22, Staff B documented the administration of medications 9 days. -From 01/01/23 through 01/26/23, Staff B documented the administration of medications 14 days. Interview with the Business Office Manager (BOM) on 01/26/23 at 5:03pm revealed: -She was still searching validation that Staff B had taken and passed the medication aide examination. -She would continue searching and forward the documentation tomorrow on 01/27/23. Telephone interview with the Resident Care Coordinator (RCC) on 01/27/23 at 4:11pm revealed: -She was sure Staff B had taken and passed the medication aide examination. -It was easy to find the proof that Staff B had passed the medication aide examination. -Staff B functioned as a MA and passed medications to the residents. Interview with the Administrator on 01/27/23 at 4:12pm revealed: -She was not aware the BOM had not sent validation that Staff B had taken and passed the medication examination. -She would make sure the information was faxed as soon as possible. -The RCC was responsible for ensuring the MAs had the required training. A request was made on 01/26/23 at 2:30pm and at 5:23pm and on 01/27/23 at 4:11pm for Staff B's validation of passing the written MA exam, but not provided by exit on 01/27/23.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D935	Continued From page 28 Staff B was not available for interviews on 01/26/23 and 01/27/23.	D935		