STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096052	A. BUILDING: _____ B. WING _____	R 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS ASSISTED LIVING	2050 US 70 WEST HWY GOLDSBORO, NC 27534

(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 on 02/16/23.	{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 A CONTINUING TYPE B VIOLATION Based on these findings, the previously Unabated Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 4 residents (#1, #2, #3) observed during the medication passes including errors with insulin (#1), a medication used to treat anxiety that was scheduled multiple times per day that was administered late (#2), a medication used to treat depression (#2), and a supplement (#3). The findings are: The medication error rate was 12% as evidenced by the observation of 4 errors out of 33 opportunities during the 8:00 a.m. and 11:00am	{D 358}		

Reviewed and Acknowledged PHR 03/09/23

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{D 358}	Continued From page 1 medication passes on 02/16/23. 1. Review of Resident #1's current FL-2 dated 06/07/22 revealed diagnoses included diabetes. Review of a physician's order sheet dated 11/25/22 revealed there was an order for Novolog 7 units before meals, hold for fingerstick blood sugar (FSBS) less than 150 (Novolog is rapid-acting insulin used to lower blood sugar. The manufacturer instructions state Novolog Flexpen should be primed with a 2-unit air dose before each use to avoid injecting air and to ensure proper dosage). Observation of the 11:00am medication pass on 02/16/23 revealed: -The medication aide (MA) performed a FSBS on Resident #1. -Resident #1's FSBS was 314 at 11:04am. -The MA administered 7 units of Novolog to Resident #1 at 11:05am. -The MA did not prime the Novolog pen with 2 units of insulin prior to administering the 7 units to Resident #1. Review of Resident #1's February 2023 medication administration record (MAR) revealed: -There was an entry for Novolog Flexpen give 7 units before meals, hold if FSBS is less than 150 scheduled for administration at 7:00am, 11:00am, and 5:00pm. -Novolog 7 units was documented as administered at 7:00am and 11:00 am on 02/16/23. Interview with the MA on 02/16/23 at 11:06am revealed she had never been trained to prime an insulin pen with 2 units of insulin prior to administration.	{D 358}	1. MAs were trained to waste 2 units of insulin with priming of pen per recommended manufacturer guidelines. Pharmacy RN was also called and discussed this error. She also helps train med aides. She had not been told of this guideline and was going to investigate. When training staff she will be aware of the recommended guideline by Manufacturer, check other types of insulin pens guidelines and train accordingly. Facility Medication admin and IC policy will be reviewed & instructions for administering insulin will be added. Will be completed by 3/3/23.	

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{D 358}	Continued From page 2 Interview with the Resident Care Coordinator (RCC) on 02/16/23 at 11:32am revealed: -She was a Registered Nurse (RN) and knew it was a "suggestion" that the Novolog Flexpen be primed with 2 units of insulin prior to administration. -She performed the clinical skills checklist for MAs prior to them administering insulin to residents. -Due to the cost of insulin, she did not train the MAs to prime insulin pens with 2 units prior to administration. -She thought priming an insulin pen with 2 units prior to administration was a suggestion and it was not specifically stated in the facility's protocol to do so. -The reason an insulin pen should be primed with 2 units of insulin prior to administration was to make sure the resident received the full dose of insulin. -If a resident did not receive a full dose of insulin, it could cause their FSBS to become too high. Review of the facility's medication administration and infection control policy revealed there were no instructions for administering insulin. Interview with Resident #1's primary care provider (PCP) on 02/16/23 at 3:36pm revealed: -She expected the facility to follow the facility protocol for priming insulin before administering it to residents. -She did not believe that Resident #1 had any adverse effects from the facility not priming his insulin prior to administration. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	{D 358}		

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{D 358}	Continued From page 3 2. Review of Resident #2's current FL-2 dated 08/09/22 revealed diagnoses included major depression. a. Review of Resident #2's FL-2 dated 08/09/22 revealed there was an order for Ativan 1mg (used to treat anxiety) three times a day. Observation of the 8:00am medication pass on 02/16/23 revealed the medication aide (MA) administered Ativan 1mg to Resident #2 at 8:41am. Review of Resident #2's medication administration record (MAR) revealed: -There was an entry for Ativan 1mg 3 times a day scheduled for administration at 6:00am, 12:00pm, and 6:00pm. -Ativan 1mg was documented as administered by the MA at 6:00am on 02/16/23. Interview with the MA on 02/16/23 at 11:10am revealed: -Resident's medications could be administered 1 hour before or 1 hour after the scheduled administration time. -She thought Resident #2's Ativan had always been scheduled to be administered at 8:00am. -She did not notice on the MAR that the administration time had been changed to 6:00am for Resident #2's Ativan. Interview with the Resident Care Coordinator (RCC) on 02/16/23 at 11:23am revealed: -Someone had handwritten a time change on Resident #2's Ativan administration times on the MAR. -She was the one who usually changed administration times on the MAR if needed.	{D 358}	2. Clarification of time for ativan 1mg to Resident #2 (whether 6am or 8am) was done with RCC. Discussion with MAs was done to not change times on MARs. Only RCC will change times with direction of PCP. Completed 2/18/23.	

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{D 358}	Continued From page 4 -She did not know who changed the administration time for Resident #2's Ativan. -Since the administration times on the MAR for Ativan were written for 6:00am, 12:00pm, and 6:00pm she expected Resident #2 to receive his Ativan within 1 hour before to 1 hour after those times. b. Review of Resident #2's current FL-2 dated 08/09/22 revealed there was an order for Lexapro 20mg (used to treat depression) daily. Observation of the 8:00am medication pass on 02/16/23 revealed: -The medication aide (MA) could not find Lexapro on the medication cart for Resident #2. -The MA looked in the medication room to see if there was Lexapro in there for Resident #2 and did not find any. -Twelve pills were administered to Resident #2 at 8:41am. -Lexapro 20mg was not administered to Resident #2. Review of Resident #2's February 2023 medication administration record (MAR) revealed: -There was an entry for Lexapro 20mg daily scheduled for administration at 7:00am. -Lexapro 20mg was documented as "med not in facility" at 7:00am on 02/16/23. Interview with Resident #2 on 02/16/23 at 10:10am revealed he did not feel that his mood was any different than usual. Interview with the MA on 02/16/23 at 11:10am revealed: -MAs were to make the Resident Care Coordinator (RCC) aware that a resident needed a refill on a medication when the medication got	{D 358}		

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{D 358}	Continued From page 5	{D 358}		

down to the blue tab on the medication card.
-The MA removed the sticker from the medication card and placed it on a medication reorder form and placed it in the RCC's box so the RCC could get it refilled.
-She thought Resident #2 just ran out of Lexapro today.

Interview with the RCC on 02/16/23 at 11:32am revealed:
-MAs should let her know that a resident needed a refill on a medication when the medication got down to the blue tab on the medication card.
-She knew to reorder medications on residents when a MA put a sticker on the medication reorder sheet and placed it on her door.
-If she was not at the facility to reorder a medication the lead MA would reorder the medication.
-She was not sure why Resident #2's Lexapro was not ordered before it ran out.

Interview with a pharmacist at the facility's contracted pharmacy on 02/16/23 at 2:58pm revealed:
-Twenty-eight tablets of Lexapro 20mg was last dispensed to Resident #2 on 02/01/23.
-The pharmacy also dispensed an emergency refill of 12 tablets of Lexapro 20mg for Resident #2 on 02/16/23.

Second interview with the RCC on 02/16/23 at 4:05pm revealed:
-She did not know why they could not find Resident #2's Lexapro that was dispensed by the facility's contracted pharmacy on 02/01/23.
-She had ordered an emergency supply of Lexapro for Resident #2.

Interview with Resident #2's primary care provider

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{D 358}	Continued From page 6 (PCP) on 02/16/23 at 3:36pm revealed the resident should not have any side effects from missing one dose of his Lexapro. 3. Review of Resident #3's current FL-2 dated 06/09/22 revealed diagnoses included schizophrenia, depression, and type 2 diabetes. Review of Resident #3's physician order sheet dated 07/05/22 revealed there was an order for Vitamin D (a supplement) 250mcg daily. Observation of the 8:00am medication pass on 02/16/23 revealed: -The medication aide (MA) could not find Vitamin D on the medication cart for Resident #3. -The MA looked in the medication room to see if there was Vitamin D in there for Resident #3 and did not find any. -Nine pills were administered to Resident #3 at 8:32am. -Vitamin D was not administered to Resident #3. Review of Resident #3's February 2023 medication administration record (MAR) revealed: -There was an entry for Vitamin D 250mcg daily scheduled for administration at 8:00am. -Vitamin D was documented as "medication not in the facility" at 8:00am on 02/16/23. Interview with the MA on 02/16/23 at 11:10am revealed: -Resident #3's family supplied his Vitamin D to the facility. -She let the Resident Care Coordinator (RCC) know when Resident #3 needed more Vitamin D and the RCC contacted the resident's family to make them aware. Interview with the RCC on 02/16/23 at 11:32am	{D 358}	3. Vit. D was bought by facility on 2/16/23 and family was contacted regarding the purchase. Facility did not want to wait for family to bring because were unsure when family could bring and did not want resident to go without meds. Completed 2/16/23.	

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{D 358}	Continued From page 7 revealed: -Resident #3's family member got his Vitamin D from an outside pharmacy. -Resident #3 ran out of Vitamin D either yesterday or today. Interview with a pharmacist at the facility's contracted pharmacy on 02/16/23 at 2:58pm revealed: -Thirty-one tablets of Vitamin D were last dispensed for Resident #3 on 10/01/22. -There was a notation in Resident #3's record that his family member called on 12/12/22 and told the pharmacy not to fill Vitamin D for Resident #3 anymore. Interview with Resident #3's family member on 02/16/23 at 3:13pm revealed: -He provided Resident #3's Vitamin D to the facility because it was cheaper than getting the medication from the facility's contracted pharmacy. -He last supplied the facility with 300 tablets of Vitamin D for Resident #3 sometime in November 2022 or December 2022. -When he brought the Vitamin D to the facility for Resident #3, he gave the medication to the RCC. Second interview with the RCC on 02/16/23 at 3:20pm revealed she was not sure when she last received Vitamin D from Resident #3's family. Interview with Resident #3's primary care provider (PCP) on 02/16/23 at 3:36pm revealed she was not concerned that he had missed a dose of Vitamin D.	{D 358}		