

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER MARJORIE MCCUNE MEMORIAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 LIONS WAY BLACK MOUNTAIN, NC 28711		
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey 04/25/23 - 04/26/23.	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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1 and #2) related to insulin administration (#2), and a antihypertensive medication, an antacid medication, and a blood thinner (#1). The findings are: 1. Review of Resident #2's current FL2 dated 03/07/23 revealed: -Diagnoses included Type 1 diabetes mellitus, chronic pancreatitis, and cognitive impairment. -There was an order to check fingerstick blood sugars (FSBS) before meals and at bedtime. -There was an order for NovoLog (a rapid acting insulin to help lower mealtime blood sugar level spikes) inject 2 units twice daily at 8:00am and 5:00pm and hold if the FSBS reading was less	D 358		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 358	Continued From page 1 than 80. Review of Resident #2's physician's orders dated 03/16/23 revealed: -There was a problems/concerns section with documentation FSBS readings showed variable high and low readings. -The eMAR suggested staff was not following hold parameters and held insulin more frequently. -There was an order for insulin compliance to be clarified by the facility staff to determine if insulin order changes were needed. -There was an order for a request for the facility staff member to contact the endocrinologist triage medical assistant and review Resident #2's eMAR discrepancies. Review of Resident #2's Care Notes revealed there was no documentation Resident #2's endocrinologist office was contacted by the facility. Review of Resident #2's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks four times a day at 8:00am, 12:00pm, 5:00pm, and 9:00pm. -There was an entry for NovoLog inject 2 units at 8:00am and 5:00pm and hold if the FSBS reading was less than 80. -There was documentation of 13 instances out of 58 opportunities between 03/01/23 through 03/31/23 when the FSBS reading was greater than 80, ranging from 81 to 173, and the NovoLog was documented as not administered with not applicable (n/a) as the reason why the insulin was not administered and the following FSBS readings ranged from 117 to 560. Review of Resident #2's 04/01/23 through	D 358		

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D 358	Continued From page 2 04/25/23 eMAR revealed: -There was an entry for FSBS checks four times a day at 8:00am, 12:00pm, 5:00pm, and 9:00pm. -There was an entry for NovoLog inject 2 units at 8:00am and 5:00pm and hold if the FSBS reading was less than 80. -There was documentation of 3 instances out of 48 opportunities between 04/01/23 through 04/25/23 where the FSBS reading was less than 80, ranging from 71 to 74, and the NovoLog was administered. Observation of Resident #2's medications available for administration on 04/25/23 at 12:05pm revealed there was a NovoLog flexpen available for administration. Interview with a medication aide (MA) on 04/25/23 at 3:07pm revealed: -Resident #2 was diabetic and his FSBS ran low and high. -She did not administer Resident #2's scheduled NovoLog at 8:00am on 03/05/23, 03/06/23, 03/11/23 and 5:00pm on 03/04/23 and 03/08/23 because she read the order on the eMAR incorrectly. -She knew she was supposed to administer Resident #2's NovoLog insulin if his FSBS reading was greater than 80. Interview with the MA supervisor on 04/26/23 at 10:17am revealed: -She did not know why she documented not applicable (n/a) for the NovoLog insulin she was supposed to administer to Resident #2 on 03/01/23-03/03/23, 03/08/23, 03/16/23, 03/18/23, and 03/28/23 when the FSBS reading was greater than 80. -Resident #2 may have refused the scheduled NovoLog because Resident #2 would sometimes	D 358		

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D 358	Continued From page 3 not feel like eating. -She was supposed to document on the eMAR refused if Resident #2 refused his NovoLog. -The facility's policy for medication administration included administering medications as ordered by the physician or documenting correctly why a medication was not administered. -She was not supposed to document not applicable on the eMAR when a medication was not administered. -She did not call Resident #2's primary care provider (PCP) when she did not administer Resident #2's insulin to see if additional orders were needed. -She and the Clinical Services Director were responsible for monthly eMAR audits, but she had not completed an audit for Resident #2. Interview with Resident #2 on 04/26/23 at 10:44am revealed: -He was born with Type 1 diabetes. -He was seen by an endocrinologist last month and was told his FSBS readings were too high. -He did not have any symptoms when his FSBS readings were elevated. -When his FSBS readings were low, he would experience abdominal pain. -The facility staff administered his medications, but he did not know if he received all his scheduled insulin medications. -He did not remember refusing any insulin injections from the facility staff. Interview with the Clinical Services Director on 04/25/23 at 12:05pm revealed: -The MA Supervisor was responsible for auditing the eMARs to make sure medications were accurate and to check for accuracy. -She or the MA Supervisor were responsible for clarifying or requesting new medication orders	D 358		

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D 358	Continued From page 4 and notifying the PCP of medication errors. -She did not know Resident #2 was administered insulin when it should have been held or not administered insulin as ordered. Interview with the Administrator on 04/25/23 at 4:10pm revealed: -She did not know some of the facility staff had not administered insulin as ordered to Resident #2 or held the scheduled insulin when Resident #2's FSBS was less than 80. -She did not know why the MAs documented not applicable instead of not administered on Resident #2's eMARs when the insulin was not administered. -The facility's registered nurse (RN) was responsible for monthly eMAR audits to make sure medications were administered as ordered. -The MAs were trained to administer medications as ordered per the facility's policy for medication administration. -The MAs were also taught diabetic training. -She expected staff to follow physician's orders and administer or hold insulin as ordered. -The MAs should have called to notify the PCP when they did not administer Resident #2's NovoLog when the FSBS was greater than 80 or when they administered the NovoLog when the FSBS was less than 80. Telephone interview with the PCP on 04/26/23 at 12:38pm revealed: -Resident #2's blood sugars were complicated since he was a Type 1 diabetic and had chronic pancreatitis which affected Resident #2's body from producing insulin and caused difficulty in controlling the diabetes. -Resident #2's NovoLog insulin should have been administered when the FSBS reading was greater than 80.	D 358		

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D 358	Continued From page 5 -Resident #2's NovoLog insulin should not have been administered when the FSBS reading was less than 80. -When the facility staff did not administer the scheduled doses of NovoLog when it was supposed to be given, it would cause an increase in Resident #2's blood sugar levels. -He expected the facility staff to administer Resident #2's insulin as ordered or call for any missed or excess doses of insulin administered to see if any new orders were needed for Resident #2. -Resident #2 could experience diabetic ketoacidosis (a serious, life-threatening complication of diabetes where the body produces excess blood acids), hospitalization, or death from not being administered his insulin. -Resident #2 could experience shakiness, dizziness causing a fall, or diabetic coma from being administered insulin when the FSBS reading was less than 80. Telephone interview with Resident #2's endocrinologist triage medical assistant on 04/26/23 at 1:21pm revealed: -Resident #2 was first seen by the endocrinologist in February 2023. -Resident #2 was seen again on 03/16/23 because the facility did not send a history of FSBS readings with Resident #2 during the February 2023 appointment and Resident #2's endocrinologist ordered a request for a facility staff member to contact her to review Resident #2's eMAR discrepancies. -The facility did not contact her regarding Resident #2's FSBS's and insulin errors so she contacted the facility on 03/27/23. -The office had an after hours call service and the facility had never contacted the office regarding Resident #2's insulin being held when the FSBS	D 358		

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D 358	Continued From page 6 was greater than 80 or being administered when the FSBS was less than 80 to see if new orders were needed for Resident #2. 2. Review of Resident #1's current FL2 dated 03/21/23 revealed diagnoses included vascular dementia and cerebral infarction (disruption of blood flow to the brain). a. Review of a physician's order dated 12/15/22 for Resident #1 revealed amlodipine (used to treat high blood pressure) 5mg take 1 and ½ tablets (7.5mg) every day. Review of Resident #1's electronic Medication Administration Record (eMAR) for March 2023 revealed: -There was an entry for amlodipine 5mg take 1 and 1/2 tablets (7.5mg) every day with an administration time of 8:00am to 10:00am. -There was documentation the amlodipine was not administered 10 times from 03/01/23 - 03/31/23. -There was documentation the amlodipine was not administered due to waiting on medication from pharmacy. Review of Resident #1's eMAR for 04/01/23 - 04/25/23 revealed: -There was an entry for amlodipine 5mg take 1 and 1/2 tablets (7.5mg) every day with an administration time of 8:00am to 10:00am. -There was documentation the amlodipine was not administered 5 times from 04/01/23 - 04/25/23. -There was documentation the amlodipine was not administered due to waiting on medication from pharmacy. Observation of Resident #1's medications available for administration on 04/25/23 at	D 358		

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D 358	Continued From page 7 11:30am revealed there was one bottle labeled amlodipine 5mg, take 1 and 1/2 tablets (7.5mg) daily. Telephone interview with the facility's contracted Physician's Assistant (PA) on 04/26/23 at 12:34pm revealed: -Resident #1 had a history of a cerebrovascular accident (CVA) (damage to the brain from interruption of blood supply). -Resident #1 was prescribed amlodipine for high blood pressure. -Not receiving the amlodipine for his blood pressure put Resident #1 at risk of increased blood pressure which could cause a CVA. Refer to the review of staff progress notes for Resident #1 dated 03/04/23 to 04/10/23. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 04/26/23 at 8:20am. Refer to the attempted telephone interview with a representative from the local pharmacy on 04/26/23 at 8:45am. Refer to the interview with the medication aide (MA) Supervisor on 04/25/23 at 10:05am. Refer to the interview with the Clinical Services Director on 04/25/23 at 10:00am. Refer to the interview with the Administrator on 04/25/23 at 4:30pm and 04/26/23 at 10:50am. Refer to the interview with Resident #1 on 04/27/23 at 11:07am. Refer to the attempted telephone interview with	D 358		

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D 358	Continued From page 8 Resident #1's Power of Attorney (POA) on 04/26/23 at 11:10am. b. Review of physician's orders dated 09/22/22 for Resident #1 revealed lisinopril (used to treat high blood pressure) 20mg daily. Review of Resident #1's electronic Medication Administration Record (eMAR) for March 2023 revealed: -There was an entry for lisinopril 20mg daily with an administration time of 8:00am to 10:00am. -There was documentation the lisinopril was not administered 10 times from 03/01/23 - 03/31/23. -There was documentation the lisinopril was not administered due to waiting on medication from pharmacy. Observation of Resident #1's medications available for administration on 04/25/23 at 11:30am revealed there was one bottle labeled lisinopril 20mg daily. Telephone interview with the facility's contracted Physician's Assistant (PA) on 04/26/23 at 12:34pm revealed: -Resident #1 had a history of a CVA. -Resident #1 was prescribed lisinopril for high blood pressure. -Not receiving the lisinopril for his blood pressure put Resident #1 at risk of increased blood pressure which could cause a CVA. Refer to the review of staff progress notes for Resident #1 dated 03/04/23 to 04/10/23. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 04/26/23 at 8:20am.	D 358		

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D 358	Continued From page 9 Refer to the attempted telephone interview with a representative from the local pharmacy on 04/26/23 at 8:45am. Refer to the interview with the medication aide (MA) Supervisor on 04/25/23 at 10:05am. Refer to the interview with the Clinical Services Director on 04/25/23 at 10:00am. Refer to the interview with the Administrator on 04/25/23 at 4:30pm and 04/26/23 at 10:50am. Refer to the interview with Resident #1 on 04/27/23 at 11:07am. Refer to the attempted telephone interview with Resident #1's Power of Attorney (POA) on 04/26/23 at 11:10am. c. Review of physician's orders dated 09/22/22 for Resident #1 revealed clopidogrel (used to thin the blood and prevent blood clots) 75mg daily. Review of Resident #1's electronic Medication Administration Record (eMAR) for March 2023 revealed: -There was an entry for clopidogrel 75mg daily with an administration time of 8:00am to 10:00am. -There was documentation the clopidogrel 75mg was not administered 13 times from 03/01/23 - 03/31/23. -There was documentation the clopidogrel was not administered due to waiting on medication from pharmacy. Observation of Resident #1's medications available for administration on 04/25/23 at 11:30am revealed there was one bottle labeled	D 358		

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D 358	Continued From page 10 clopidogrel 75mg daily. Telephone interview with the facility's contracted Physician's Assistant (PA) on 04/26/23 at 12:34pm revealed: -Resident #1 had a history of a CVA. -Resident #1 was prescribed the clopidogrel as a blood thinner and not receiving it could increase his risk of a CVA. Refer to review of staff progress notes for Resident #1 dated 03/04/23 to 04/10/23. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 04/26/23 at 8:20am. Refer to the attempted telephone interview with a representative from the local pharmacy on 04/26/23 at 8:45am. Refer to the interview with the medication aide (MA) Supervisor on 04/25/23 at 10:05am. Refer to the interview with the Clinical Services Director on 04/25/23 at 10:00am. Refer to the interview with the Administrator on 04/25/23 at 4:30pm and 04/26/23 at 10:50am. Refer to the interview with Resident #1 on 04/27/23 at 11:07am. Refer to the attempted telephone interview with Resident #1's Power of Attorney (POA) on 04/26/23 at 11:10am. d. Review of physician's orders dated 09/22/23 for Resident #1 revealed famotidine (used to treat and prevent acid indigestion) 20mg twice daily.	D 358		

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D 358	Continued From page 11 Review of Resident #1's electronic Medication Administration Record (eMAR) for March 2023 revealed: -There was an entry for famotidine 20mg twice daily with administration times of 8:00am and 6:00pm. -There was documentation the famotidine was not administered 19 times from 03/01/23 - 03/31/23. -There was documentation to read the staff progress notes regarding the famotidine. Review of Resident #1's electronic Medication Administration Record (eMAR) for 04/01/23 - 04/25/23 revealed: -There was an entry for famotidine 20mg twice daily with administration times of 8:00am and 6:00pm. -There was documentation the famotidine was not administered 11 times from 04/01/23 - 04/25/23. -There was documentation to read the staff progress notes regarding the famotidine. Observation of Resident #1's medications available for administration on 04/25/23 at 11:30am revealed there was one bottle labeled famotidine 20mg twice daily. Telephone interview with the facility's contracted Physician's Assistant (PA) on 04/26/23 at 12:34pm revealed: -Resident #1 was prescribed famotidine for increased stomach acid. -Not receiving famotidine put Resident #1 at risk of increased stomach acid. Refer to review of staff progress notes for Resident #1 dated 03/04/23 to 04/10/23.	D 358		

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D 358	Continued From page 12 Refer to the telephone interview with a representative from the facility's contracted pharmacy on 04/26/23 at 8:20am. Refer to the attempted telephone interview with a representative from the local pharmacy on 04/26/23 at 8:45am. Refer to the interview with the medication aide (MA) Supervisor on 04/25/23 at 10:05am. Refer to the interview with the Clinical Services Director on 04/25/23 at 10:00am. Refer to the interview with the Administrator on 04/25/23 at 4:30pm and 04/26/23 at 10:50am. Refer to the interview with Resident #1 on 04/27/23 at 11:07am. Refer to the attempted telephone interview with Resident #1's Power of Attorney (POA) on 04/26/23 at 11:10am. _____ Review of the staff progress notes for Resident #1 dated 03/04/23 to 04/10/23 revealed: -There was documentation the medications had not arrived from the local pharmacy and the resident was still waiting on the medications from the local pharmacy. -There was documentation the Supervisor attempted to get the medications from the local pharmacy. -There was no documentation staff had communicated the need for Resident #1's medications from the facility's back up contracted pharmacy. Telephone interview with a representative from	D 358		

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D 358	Continued From page 13 the facility's contracted pharmacy on 04/26/23 at 8:20am revealed: -The pharmacy entered Resident #1's medications into the eMAR system via data entry. -Resident #1's medications were dispensed by another pharmacy. -If the facility had difficulty getting the other pharmacy to dispense Resident #1's medications, the facility would need to communicate that with the pharmacy and the medications would be dispensed. -The pharmacy had not received any communication from the facility about the need for any of Resident #1's medications in the months of March or April 2023. Interview with the medication aide (MA) Supervisor on 04/25/23 at 10:05am revealed: -She was responsible for ensuring the residents' medications were in the facility. -She would audit the medication carts once every two to three weeks to ensure medications were available and if not, would reach out to the appropriate pharmacy. -She knew Resident #1 did not have some of his medications to administer in March and April 2023. -It had been difficult to obtain Resident #1's medications from the local pharmacy. -She had contacted numerous staff at the local pharmacy about the need for the medications. -She had not contacted the facility's contracted pharmacy because they would only dispense over the counter medications for Resident #1. -She had documented each time she contacted the local pharmacy in a notebook but could not locate the notebook. Interview with the Clinical Services Director on 04/25/23 at 10:00am revealed:	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER MARJORIE MCCUNE MEMORIAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 LIONS WAY BLACK MOUNTAIN, NC 28711		
(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 358	Continued From page 14 -The MA Supervisor was responsible for auditing the medication carts to ensure medications were available to administer. -The MA Supervisor would contact the appropriate pharmacy for refills. -She knew some medications were not available to administer to Resident #1 in March and April 2023. -She had informed the MA Supervisor that Resident #1 was out of medications. -She knew the Supervisor had contacted the facility's contracted pharmacy but the pharmacy had informed her that Resident #1's medications were dispensed by the local pharmacy. Interview with the Administrator on 04/25/23 at 4:30pm and 04/26/23 at 10:50am revealed: -The facility's Registered Nurse (RN) was responsible for auditing the eMARs monthly for missed medications. -The facility's contracted pharmacy should have been contacted as the back up pharmacy for Resident #1's medications. -She thought that Resident #1 only wanted the local pharmacy to dispense his medications. -She did not know why the facility's contracted pharmacy was not contacted. Interview with Resident #1 on 04/26/23 at 11:07am revealed: -He did not remember if he had missed any medications in March or April 2023. -He did not remember if staff had asked him permission to use the facility's contracted pharmacy for his medications. Attempted telephone interview with a representative from the the local pharmacy on 04/26/23 at 8:45am was unsuccessful.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER MARJORIE MCCUNE MEMORIAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 LIONS WAY BLACK MOUNTAIN, NC 28711		
(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 358	Continued From page 15 Attempted telephone interview with Resident #1's Power of Attorney (POA) on 04/26/23 at 11:10am was unsuccessful. The facility failed to ensure medications were administered as ordered for Resident #2 who was not administered insulin when the blood sugar reading was greater than 80 resulting in subsequent elevated blood sugar readings up to 560 and placed Resident #2 at risk of developing diabetic ketoacidosis, hospitalization, and/or death, and administered insulin when the blood sugar reading was less than 80 placing Resident #2 at risk of going into a diabetic coma, and to administer medications to reduce blood pressure and a blood thinner to Resident #2 who had a history of a stroke. This failure was detrimental to the health and safety of Resident #1 and #2 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/25/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 10, 2023.	D 358		