STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060157	A. BUILDING: _____ B. WING _____	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON FAMILY CARE HOME	13418 HAMILTON ROAD CHARLOTTE, NC 28278

(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 and the Mecklenburg Deptartment of Social Services conducted an annual survey on 09/10/24.	C 000		
C 204	10A NCAC 13G .0702 (c) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination and Immunizations (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the examining date documented on the resident's FL2 was no more than 90 days prior to admission for 1 of 2 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 06/09/23 revealed: - Diagnoses included dementia, diabetes mellitus, hypertension, and congestive heart failure. - Resident #1's recommended level of care was assisted living. Review of Resident #1's Resident Register revealed a date of admission was not documented.	C 204	Resident number one, FL2 corrective action was immediately documented and signed by the provider on 9/10/2024. Other corrective action will include timely completion of FL2 and filed in residence charts. Weekly FL2 audits of all residents will be conducted to reflect appropriate documentation and date required by section C 204 for six weeks The first audit was completed on 10/1/24 facility RN educated on timely documentation of FL2 Quarterly quality check will include FL2 documentation. Administrator and RN will meet monthly to ensure FL2 documentation is in place for three months	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Verified by pdfFiller 10/09/2024
10/9/24

Reviewed and Acknowledged by MH on 10/10/2024

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C 204	Continued From page 1 Review of Resident #1's record on 09/10/24 revealed there was no documented FL-2 for Resident #1 since 06/09/23. Telephone interview with Resident #1's Nurse Practitioner on 09/10/24 at 2:15pm revealed: -Resident #1 was admitted to hospice care on 07/18/24. -She conducted a plan of care assessment with Resident #1 in July 2024. -Residents were required to have a current FL-2 upon admission and annually thereafter. -She did not know Resident #1's FL-2 expired on 06/09/24. -The facility was responsible for notifying the healthcare provider to obtain a current FL-2. Telephone interview with Resident #1's contracted hospice RN on 09/10/24 at 3:05pm revealed: -Residents were required to have a current FL-2 upon admission and annually thereafter. -She did not know Resident #1's FL-2 dated 06/09/23 was not current. -The facility was responsible for notifying her to update Resident #1's FL-2. -The facility did not request a current FL-2 for Resident #1. Interview with the facility's RN on 09/10/24 at 3:30pm revealed: -She was responsible for ensuring residents records were organized and accurate. -She completed monthly audits of resident records. -She was aware residents required a current FL-2 upon admission and at least annually thereafter. -She may have provided an FL-2 in June 2024 to Resident #1's former contracted Physician's	C 204		

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C 204	Continued From page 2 Assistant to sign. -She may have provided an FL-2 in July 2024 to Resident #1's contracted hospice Nurse Practitioner to sign. -She was unable to locate a current physician signed FL-2 for Resident #1. Interview with the Administrator on 09/10/24 between 11:00am and 4:00pm revealed: -He was aware residents required a current FL-2 upon admission and at least annually thereafter. -Resident's FL-2 documentation was maintained in each resident's resident record. -He did not know Resident #1's FL-2 dated 06/09/23 was expired. -The facility's RN was responsible to ensure residents records had a current FL-2.	C 204		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires	C 231	Care plan for resident number was immediately documented on 9/10/24 and signed by the provider. Facility RN educated on 10/1/24 on timely documentation of care plan and filling in residence charts. Weekly audit of care plan documentation and timely completion will be conducted by RN to ensure timely completion and filing in the chart for six weeks. Administrator and RN will meet monthly to ensure FL2 documentation is in place for three months.	

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C 231	Continued From page 3 referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled residents (Resident #1) had an assessment and care plan updated annually. The findings are: Review of Resident #1's FL-2 dated 06/09/23 revealed: - Diagnoses included dementia, diabetes mellitus, hypertension, and congestive heart failure. - Resident #1's recommended level of care was assisted living. Review of Resident #1's Resident Register revealed a date of admission was not documented. Review of Resident #1's record on 09/10/24 revealed: -Resident #1 was admitted to the facility on 06/11/23. -Resident #1's Primary Care Provider (PCP) signed the care plan on 06/15/23. -There were no additional documented care plans. Interview with the facility's Registered Nurse (RN) on 09/10/24 at 3:30pm revealed: -She was responsible for ensuring residents records were current. -She conducted a monthly audit of Resident #1's	C 231	Facility RN educated on 10/1/24 on timely documentation of care plan and filling in residence charts. Weekly audit of care plan documentation and timely completion will be conducted by RN to ensure timely completion and filing in the chart for six weeks. Administrator and RN will meet monthly to ensure FL2 documentation is in place for three months	

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C 231	Continued From page 4 record. -She thought she completed a new care plan for Resident #1 in December of 2023 but was unable to locate it. -She put all care plans in a folder for the PCP to sign. -Once it was signed, she would put the care plan in the resident's record. -She was unable to locate a current physician signed care plan for Resident #1. Interview with the Administrator on 09/10/24 between 11:00am and 4:00pm revealed: -He was aware residents required a current care plan within 30 days of admission, a significant change, and annually thereafter. -He did not know Resident #1's care plan dated 06/11/23 had expired. -The facility's RN was responsible to ensure residents records had a current physician signed care plan.	C 231		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family 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 record.	C 315	Resident number one,Lantus order was immediately clarified and new parameters to hold and document evening and morning blood sugars per MD orders.Order clarification was given by residents provider on 9/10/24. Staff education provided to nurses on order clarification and medication review to ensure insulin orders are clearly stated to reflect compliance with C 315 on 9/28/24.Weekly audit for order Clarification and Order review every six weeks. Completion of diabetic training and certificate of completion for employees	

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C 315	Continued From page 5 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure clarification of a medication order for 1 of 2 sampled residents (Resident #1) related to an order for a medication to lower blood glucose levels. The findings are: Review of Resident #1's FL2 dated 06/09/23 revealed: - Diagnoses included dementia, diabetes mellitus, hypertension, and congestive heart failure. - Resident #1's recommended level of care was assisted living. -There was an entry under medications to "see list". Review of Resident #1's record revealed: -A signed Physician's Order Summary dated 05/28/24. -There was an order dated 06/17/23 to check Finger Stick Blood Sugar (FSBS) twice daily at 8:00am and 8:00pm. -There was an order dated 06/16/24 for Lantus (a long-acting insulin used to lower elevated blood sugar levels) 100/ml, inject 55 units subcutaneously at bedtime with instructions to hold if blood glucose less than 200. -A Physician's order dated 07/29/24 for Lantus 100/ml, inject 20 units subcutaneously daily at bedtime with no additional instructions. Review of Resident #1's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus 100/ml, inject 20 units subcutaneously daily at bedtime with no additional instructions.	C 315		

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C 315	Continued From page 6 -There were 12 instances out of 31 opportunities when Resident #1's Lantus 20 units was documented as not administered with an exception which stated withheld per physician's orders. -There was no field to document the evening FSBS. Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus 100/ml, inject 20 units subcutaneously daily at bedtime with no additional instructions. -There was no field to document the evening FSBS. -There was 1 instance out of 9 opportunities when Resident #1's Lantus 20 units was documented as not administered with an exception which stated withheld per physician's orders. Attempted interview with Resident #1 on 09/10/24 at 11:00am was unsuccessful. Telephone interview with Resident #1's contracted hospice Registered Nurse (RN) on 09/10/24 at 3:05pm revealed: -Resident #1 was admitted to hospice care on 07/18/24. -She assessed Resident #1 weekly and reviewed his blood sugars. -Resident #1 was prescribed Lantus 20 units to be administered daily at bedtime. -Resident #1 was prescribed an additional blood glucose medication to be administered daily every morning. -Beginning in August 2024, the Administrator notified her weekly of Resident #1's daily FSBS results.	C 315		

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-The Administrator notified her that on occasion he withheld Resident #1's Lantus 20 units at bedtime due to bedtime FSBS results less than 200.
-She misunderstood the Administrator's notification of withholding Resident #1's Lantus 20 units for Resident #1's and thought it was for the morning blood glucose medication.
-She was not concerned that it was held as the Administrator knew the resident very well and made the correct clinical judgment but knew there should have been an order with instructions.
-Resident #1 did not eat much and his FSBS ranged from 90 - 300.

Telephone interview with Resident #1's Nurse Practitioner on 09/10/24 at 2:15pm revealed:
-Resident #1 was admitted to hospice care on 07/18/24.
-Resident #1's blood glucose was uncontrolled and required medication adjustment.
-On 07/29/24 she changed Resident #1's Lantus 55 units daily at bedtime to 20 units at bedtime.
-On 07/29/24, she did not write the order for Lantus 20 units to be held for FSBS Resident #1's Lantus 20 units to be held for FSBS results.
-She was not made unaware the facility withheld Resident #1's Lantus 20 units in August 2024 for 12 of 31 opportunities.
-She was not made aware the facility withheld Resident #1's Lantus 20 units in September 2024 for 1 of 9 opportunities.
-She would have expected the facility to notify her if staff withheld Resident #1's Lantus 20 units daily at bedtime for a FSBS less than 200.
-She would have expected the facility to request clarification of Resident #1's Lantus 20 units daily at bedtime to include instructions to hold medication if FSBS were less than 200.
-It was an oversight that the prescription order did

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not have instructions to hold the medication if his blood sugar was less than 200.
-It was the right clinical judgment to withhold the medication, but the facility should have clarified the order.

Interview with the Administrator on 09/10/24 at 4:00pm revealed:
-He was a Licensed Practical Nurse (LPN).
-He and the facility RN were responsible to administer Resident #1's medications as ordered.
-Resident #1 was admitted to hospice on 07/18/24.
-Prior to Resident #1's admission to hospice care, Resident #1 had an order for Lantus 55 units to be administered daily at bedtime with instructions to hold the medication if Resident #1's bedtime FSBS was less than 200.
-In August 2024, Resident #1's Lantus 55 units was changed to Lantus 20 units to be administered daily at bedtime.
-He tested Resident #1's FSBS every evening prior to administration of Resident #1's Lantus 20 units.
-He documented the results in the eMar under a note section.
-He was unable to retrieve the information regarding the FSBS.
-In August 2024 and September 2024, on occasion he withheld Resident #1's Lantus 20 units daily at bedtime because Resident #1's evening FSBS result was less 200 and giving Resident #1 the medication could be detrimental to his health.
-In August 2024, he notified the hospice RN weekly of Resident #1's FSBS results and withholding Resident #1's Lantus 20 units at bedtime.
-He was aware the facility required a physician's order with instructions if a medication was to be

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C 315	Continued From page 9 administered or withheld.	C 315		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the accuracy of Medication Administration Records (MARs) for 1 of 2 sampled residents (Resident #1) related to documentation for administration of a blood glucose medication. The findings are: Review of Resident #1's FL2 dated 06/09/23	C 342		

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C 342	Continued From page 10 revealed: - Diagnoses included dementia, diabetes mellitus, hypertension, and congestive heart failure. - Resident #1's recommended level of care was assisted living. -There was an entry under medications to "see list". Review of Resident #1's record revealed: -A signed Physician's Order Summary dated 05/28/24. -There was an order dated 06/17/23 to check Finger Stick Blood Sugar (FSBS) twice daily. -There was an order dated 06/16/23 for Insulin lispro 100/ml, inject 12 units subcutaneously before meals with instructions to hold for blood sugars less than 200. Review of Resident #1's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for insulin lispro, 100u/ml inject 12 units subcutaneously once daily at 8:00am with instructions to only administer if FSBS was greater than 200. -On 07/21/24 at 8:00am the residents FSBS was 146 and Lispro 12 units was documented as administered. - On 07/29/24 at 8:00am the residents FSBS was 75 and lispro 12 units was documented as administered. Review of Resident #1's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for insulin lispro, 100u/ml inject 12 units subcutaneously once daily at 8:00am with instructions to only administer if FSBS was greater than 200. -Between 08/01/24 and 08/31/24, lispro 12 units	C 342	Staff education provided on 9/28/24 regarding appropriate withholding and administering of insulin lispro using parameters given per MD order. Notify MD of any changes to ensure compliance C 342. Weekly audit and review blood sugar and administration of lispro insulin within parameters provided by MD order. Complete diabetic training and certificate completion for employees	

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was documented as administered on 8 occasions when the documented FSBS was less than 200.

Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for insulin lispro, 100/ml, inject 12 units subcutaneously once daily at 8:00am with instructions to only administer if FSBS was greater than 200.
-Between 09/01/24 and 09/10/24, lispro 12 units was documented as administered on 7 occasions when the documented FSBS was less than 200.

Attempted interview with Resident #1 on 09/10/24 at 11:00am was unsuccessful.

Telephone interview with Resident #1's Nurse Practitioner on 09/10/24 at 2:15pm revealed:
-Resident #1 had an order for insulin 100/ml, inject 12 units daily at 8:00am if FBSB was greater than 200.
-She expected facility staff to accurately document Resident #1's morning insulin 100/ml 12 units and FSBS results accurately.
-She did not know Resident #1's insulin 100/ml 12 units had been documented as administered between July 2024 and September 2024 with a documented FSBS below 200.

Interview with the Administrator on 09/10/24 at 4:00pm revealed:
-He was a Licensed Practical Nurse (LPN).
-Resident #1 had an order to administer insulin lispro 100/ml, 12 units subcutaneously every morning if his FBSB was greater than 200.
-He and the facility RN were responsible to accurately document administration of Resident #1's medications on the eMAR.
-Staff were expected to document administration

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C 342	Continued From page 12 of Resident #1's insulin lispro 100/ml 12 units daily only if Resident #1's morning FSBS was greater than 200. -He did not know Resident #1's eMAR between July 2024 and September 2024 had documented administration of Resident #1's insulin 100/ml 12 units with a documented daily FSBS below 200. -He must had entered in error as he knew he would not have given the medication if his FSBS was under 200.	C 342		