Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL090033	A. BUILDING: _____ B. WING _____	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE MANOR ASSISTED LIVING BUILDING II	1101 BAUCOM ROAD MONROE, NC 28110

(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 and Union County Department of Social Services conducted an annual survey and complaint investigation on October 15, 2024. The complaint was initiated by the Union County Department of Social Services on October 8, 2024.	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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents sampled (#2) related to a medication used to lower blood sugar levels. The findings are: Review of Resident #2's current FL2 dated 06/04/24 revealed diagnoses included uncontrolled diabetes mellitus with hyperglycemia, urinary tract infection, primary hypertension. Review of Resident #2's primary care provider's (PCP) order dated 06/27/24 revealed: -There was an order to check blood glucose (BG) 1 hour after each meal.		(1) All diabetic residents' orders reviewed to ensure they have been administered properly and there are no errors. (2) Staff re-educated on administering insulin and diabetic training. The administrator will check staff on administering insulin weekly x4 wee The administrator will check staff on administering insulin monthly. (3) Staff re-educated on medication administration. The administrator will check staff weekly x 4 weeks to ensure that medications are being administered properly. The administrator will check staff monthly to ensure that medications are being administered properly. (4) This will be completed by 11/5/2024.	

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

Kashina Rivers, administrator | 10-29-24

Reviewed and acknowledged on 11/04/24 by JL

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-There was an order for Novolog 5 units if BG was greater than 150 (Novolog is a rapid acting injectable medication used to lower blood sugar levels).

Review of Resident #2's PCP order dated 09/05/24 revealed there was an order to change the time of Novolog 5 units, 1 hour after each meal at 9:00am, 1:00pm, and 6:00pm.

Review of Resident #2's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog Flexpen, 1 hour after each meal check BG. If greater than 150, give 5 units Novolog scheduled for 8:00am,12:00pm, and 5:00pm.
-Novolog Flexpen was documented as administered or held appropriately according to parameters at 8:00am, 12:00pm, and 5:00pm on 92 of 93 opportunities from 08/01/24 to 08/31/24.
-On 08/16/24 at 8:00am, Resident #1's BG was documented as 177 and Novolog Flexpen 5 units was documented as held when the medication should have been administered.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for Novolog Flexpen, 1 hour after each meal check BG. If greater than 150, give 5 units Novolog scheduled for 9:00am, 1:00pm, and 6:00pm.
-Novolog Flexpen was documented as administered or held appropriately according to parameters on 41 of 43 opportunities.
-On 10/04/24 at 9:00am, Resident #2's BG was documented as 137, and Novolog Flexpen was documented as administered when the medication should have been held.
-On 10/07/24 at 6:00pm, Resident #2's BG was

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documented as 144 and Novolog Flexpen was documented as administered when the medication should have been held.

Interview with Resident #2 on 10/15/24 at 3:25pm revealed:
-She had a continuous blood glucose monitoring device and that was how the staff checked her BG levels.
-She was supposed to receive an insulin injection after meals if her BG was higher than 150.
-If her BG was lower than 150, she was not supposed to receive the insulin.
-She had received insulin before when her BG was less than 150, but she was unsure of the dates.

Telephone interview with a medication aide (MA) on 10/15/24 at 2:39pm revealed:
-He checked Resident #2's BG before he administered Resident #2's insulin.
-If Resident #2's BG was higher than 150, there was an order to give Resident #2's insulin.
-If Resident #2's BG was less than 150, Resident #2 was not supposed to receive insulin.
-He was working on 10/07/24 at the time Resident #2 was scheduled for her 6:00pm dose of Novolog.
-He checked Resident #2's BG and her BG was less than 150, so he did not administer Novolog 5 units on 10/07/24 at 6:00pm.
-He accidentally clicked on Resident #2's Novolog on the eMAR, so the eMAR documentation showed he administered Novolog, but he did not administer Novolog 5 units to Resident #2 at 6:00pm on 10/07/24.
-He was unable to correct the documentation on the eMAR, so he contacted the Administrator on 10/07/24 and reported the eMAR documentation was not correct.

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Interview with the Administrator on 10/15/24 at 2:55pm revealed:
-MAs should read the residents' eMARs and follow the orders on the eMARs.
-Resident #2's had an order for her BG to be checked an hour after meals at 9:00am, 1:00pm, and 6:00pm.
-Resident #2 should not receive insulin if her BG was less than 150.
-She was unsure why Resident #2's Novolog was documented as administered when her BG was less than 150 on 10/04/24 at 9:00am and 10/07/24 at 6:00pm.
-The MA did not notify her on 10/07/24 at 6:00pm that he documented Resident #2's insulin incorrectly.
-The facility's internet was slow at times and sometimes caused issues with documenting on the eMAR.

Attempted telephone interview with a second MA on 10/15/24 at 3:18pm was unsuccessful.

Attempted telephone interview with Resident #2's PCP on 10/15/24 at 2:30pm was unsuccessful.