Division of Health Service Regulation

PRINTED: 12/20/2024
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HA1374536	A. BUILDING: _____ B. WING _____	12/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HAVEN ASSISTED LIVING	668 MATTOX ROAD GREENVILLE, SC 27834

(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 an Annual survey and Complaint Investigation from 11/13/24 to 11/14/24.	D 000	This Plan of correction is submitted in Compliance with Statutory and regulatory requirements and should not be Construed as an Admission of agreement with the findings, scope, or severity of any of the deficiencies Cited.	
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 interviews, observations, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (5) including a medication used to treat high blood sugar. The findings are: Review of Resident #5's current FL-2 dated 02/14/24 revealed: -Diagnoses included diabetes mellitus, Alzheimer's dementia, and hypertension. -There was an order for Novolog Flexpen (a rapid-acting insulin used to treat high blood sugar) 100units/ml, check fingerstick blood sugar (FSBS) 3 times a day with meals, inject sliding scale insulin (SSI).5 units for a FSBS of 150-200, 10 units for a FSBS over 200, call primary care provider (PCP) if FSBS less than 60 or greater than 400. -The resident's level of care was special care unit	D 358	Oak Haven Assisted living will administer record medications and treatment orders on the medication Administration record and shall be accurate and include all required components Immediate Action. All medication Aides will be provided CEU Class on Diabetes & insulin Administration by the Pharmacy	1-16-24 12-24-24

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shelley Story
TITLE: Administrator
DATE: 12-23-24

STATE FORM 6899 GPVD11 If continuation sheet 1 of 5

Reviewed and Acknowledged KC 12/31/24

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D 358	Continued From page 1 (SCU). Review of a medication change request for Resident #5 from the facility's contracted pharmacy dated 04/19/24 revealed a request to change from Novolog Flexpen to Fiasp FlexTouch (Fiasp is a rapid-acting insulin used to treat high blood sugar) and was signed by Resident #5's PCP. Review of Resident #5's signed physicians order sheet dated 07/24/24 revealed an order for Fiasp FlexTouch, check blood glucose three times per day with meals, inject 5 units for a FSBS of 150-200, inject 10 units for FSBS over 200, notify PCP if FSBS is less than 60 or greater than 400. Review of Resident #5's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Fiasp FlexTouch, check blood glucose three times a day with meals, inject 5 units for a FSBS of 150-200, inject 10 units for FSBS over 200, notify PCP if FSBS is less than 60 or greater than 400, scheduled for administration at 8:00am, 12:00pm, and 5:00pm. -Fiasp 5 units was documented as administered on 09/21/24 at 5:00pm for a FSBS of 263 when 10 units should have been administered. Review of Resident #1's October 2024 eMAR revealed: -There was an entry for Fiasp FlexTouch, check blood glucose three times per day with meals, inject 5 units for a FSBS of 150-200, inject 10 units for FSBS over 200, notify PCP if FSBS is less than 60 or greater than 400, scheduled for administration at 8:00am, 12:00pm, and 5:00pm. -Fiasp 5 units was documented as administered on 10/06/24 at 5:00pm for a FSBS of 220 when	D 358	Systemic Change: An Audit form will be put in place for all diabetic residents. At the first of each business week the RCC will complete and turn in to the Administrator. This will notate any issues found. Then if any were found Documentation provided to the physician.	12-1-24 12-1-25

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D 358	Continued From page 2 10 units should have been administered. -Fiasp 200 units was documented as administered on 10/10/24 at 5:00pm for a FSBS of 283 when 10 units should have been administered. -Fiasp 5 units was documented as administered on 10/26/24 at 5:00pm for a FSBS of 222 when 10 units should have been administered Telephone interview with a representative with the facility's contracted pharmacy on 11/14/24 at 11:27am revealed: -An order was received on 04/23/24 to change Resident #5's Novolog to Fiasp FlexTouch; check FSBS three times a day with meals, inject 5 units for FSBS of 150-200, inject 10 units for FSBS greater than 200, notify PCP of FSBS less than 60 or greater than 400. -Fiasp FlexTouch was last dispensed on 10/23/24, 09/24/24, and 08/20/24 for one 300unit (3ml) pen each time. Observation of Resident #5's medication on hand on 11/14/24 at 9:21am revealed there was a blue plastic zip closure bag with a medication label from the facility's contracted pharmacy, which included Resident #5's name, and Fiasp Flex Touch, check blood glucose three times a day with meals; 150-200=5 units, over 200=10 units, notify PCP if FSBS is less than 60 or greater than 400 dispensed on 10/23/24, the labeled blue bag contained one Fiasp Flex Touch 300ml pen labeled with Resident #5's name and an opened date of 10/26/24. Interview with a medication aide (MA) in the SCU on 11/14/24 at 9:40am revealed: -The MAs were to always check medication against the eMAR for orders. -When a resident received SSI, the MAs checked	D 358	All medication administration must be documented in the residents MAR. If the order is not present or has inaccuracies, this should be brought to the Administrator's Corrected immediately Monthly Audits will be conducted on all residents and their Medications to ensure accuracy. 12-17-24 to ongoing All Medication Aides will continue to maintain their Diabetic & insulin training. ongoing	

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D 358	Continued From page 3 the resident' FSBS, and administered insulin based on what was ordered on the resident's eMAR. -The MAs documented the resident's FSBS and the number of SSI units administered on the eMAR. -She was not sure why the MA administered 5 units of insulin to Resident #5 instead of 10 units when her FSBS was over 200. -She felt the MA documented 200 units of Fiasp administered to Resident #5 at 5:00pm on 10/10/24 in error. Interview with the Special Care Unit Coordinator (SCUC) on 11/14/24 at 10:37am revealed: -The MAs were to always check medications against the eMAR for orders. -If a resident was on SSI, the MA checked the resident's FSBS and referred to the resident's eMAR for the correct insulin dosage based on the FSBS and the order on the eMAR. -The MA that made the insulin errors was currently on leave and unavailable for interview. -She was certain the MA's documentation on 10/10/24 at 5:00pm that Resident #5 received 200 units of Fiasp was an error. -She performed monthly eMAR audits which included comparing FSBS to SSI units administered. -She did the eMAR audits at the first of the month for the previous month. -She last performed the eMAR audit around 11/01/24 for October 2024. -She did not catch the Fiasp insulin errors for Resident #5 in September 2024 or October 2024. -It was an oversight on her part that she did not catch the Fiasp errors for Resident #5 on the September 2024 and October 2024 eMAR audit. -If she had caught Resident #5's Fiasp errors, she would have discussed with the MA and	D 358		

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D 358	Continued From page 4 completed a medication error report for each error and faxed to Resident #5's PCP. Interview with the Administrator on 11/14/24 at 11:42pm revealed: -The MAs were trained to review the eMARs for medication orders. -The MAs were to always compare the residents' medications to the residents' eMAR prior to medication being administered. Telephone interview with Resident #5's PCP on 11/14/24 at 2:42pm revealed: -She prescribed Fiasp for Resident #5 for diabetes and elevated blood sugar. damage to eyesight, nerves, kidneys and the heart. -Resident #5's blood sugars have never been tightly controlled because her appetite and diet fluctuated. -Resident #5 should have received the appropriate amount of SSI for blood sugars over 200 to better control her blood sugars. -She was certain the documentation that Resident #5 received 200 units of Fiasp at 5:00pm on 10/10/24 was an error because if Resident #5 had received that high of a dose of Fiasp, it could have been a fatal outcome.	D 358		