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
	HAL043026	A. BUILDING: ______ B. WING ______	R 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 March 13,14 and 15, 2018.	{D 000}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult 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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to clarify and verify medication orders for 1 of 5 residents (#4) sampled who stopped receiving a long-acting insulin at bedtime in November 2017 without an order to discontinue the insulin and no documentation to clarify if the resident should have continued to receive the bedtime dose of insulin. The findings are: Review of Resident #4's current FL-2 dated 11/01/17 revealed: -Diagnoses included dementia, diabetes mellitus,	D 344	RCC will ensure all unsure orders are clarified by	3/24/18

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Manager (X6) DATE: 4/16/18

STATE FORM 6899 DQK813

Plan of Correction REVIEWED — [signature] RN 6-11-18

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D 344	Continued From page 1 hypertension, depression, hypothyroidism, and ear infection. -There was an order for Levemir 18 units every morning. (Levemir is long-acting insulin, up to 24 hour duration of action, used to lower blood sugar.) -There was an order for Levemir 18 units at bedtime. Review of Resident #4's six month physician's orders sheet dated 11/12/17 revealed both orders for Levemir 18 units in the morning and Levemir 18 units at bedtime were included on the signed order sheet. Review of a communication form from the pharmacy to the facility dated 11/06/17 for Resident #4 revealed: -The pharmacy noted Levemir 18 units every morning for diabetes was not covered by the resident's insurance. -There was a medication change request to change Levemir to Lantus which was covered by the resident's insurance. (Lantus is long-acting insulin, lasts up to 24 hours, used to lower blood sugar.) -There was no documentation on the form related the order for Levemir 18 units at bedtime. -The physician responded on 11/13/17 and wrote Lantus 18 units every morning for diabetes. -There was no documentation regarding the bedtime dose of Levemir. Review of Resident #4's January 2018 medication administration record (MAR) revealed: -There was an entry for Lantus 18 units every morning and it was documented as administered daily at 8:00 a.m. -There was no entry for a bedtime dose of Lantus or Levemir.	D 344	attending doctor and faxed to the pharmacy for proper input. RCC will assure that the pharmacy added the proper order. This will be supervised by Admin/manager.	3-16-18

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D 344	Continued From page 2 -The resident's blood sugar ranged from 62 - 361 from 01/01/18 - 01/31/18. Review of Resident #4's February 2018 MAR revealed: -There was an entry for Lantus 18 units every morning and it was documented as administered daily at 8:00 a.m. -There was no entry for a bedtime dose of Lantus or Levemir. -The resident's blood sugar ranged from 72 - 487 from 02/01/18 - 02/28/18. Review of Resident #4's March 2018 MAR revealed: -There was an entry for Lantus 18 units every morning and it was documented as administered daily at 8:00 a.m. from 03/01/18 - 03/13/18. -There was no entry for a bedtime dose of Lantus or Levemir. -The resident's blood sugar ranged from 123 - 330 from 03/01/18 - 03/13/18. Observation of Resident #4's medications on hand on 03/14/18 revealed: -There was one vial of Lantus insulin with instructions to inject 18 units every morning. -There was no Levemir or any other Lantus in the medication cart. Review of Resident #4's physician's orders revealed: -There was no order to discontinue Levemir 18 units at bedtime. -There was no order to change the Levemir 18 units at bedtime to Lantus at bedtime. -There was no order to clarify whether the resident was supposed to continue to receive a long-acting insulin at bedtime.	D 344		

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D 344	Continued From page 3 Review of Resident #4's pharmacy recommendation notes dated 01/22/18 revealed: -The pharmacist noted the bedtime dose of Levemir had not been changed when the morning dose was changed to Lantus. -The pharmacist indicated the bedtime dose needed to be clarified. Interview with the Care Coordinator (CC) on 03/13/18 at 5:00 p.m. revealed: -She had not noticed the bedtime dose for Resident #4's Levemir had not been changed when the morning dose was changed to Lantus in November 2017. -She was not aware of an order to discontinue the bedtime dose of Levemir but she would look for one. -She had not contacted the primary care provider (PCP) to clarify the order for Levemir 18 units at bedtime. -She or the MAs were responsible for clarifying medication orders. -She would check with the PCP about the bedtime insulin. Telephone interview with a pharmacist from the facility's primary pharmacy on 03/14/18 at 4:34 p.m. revealed: -Levemir 18 units in the morning and Levemir 18 units at bedtime was included on Resident #4's FL-2 dated 11/01/17. -The resident's insurance did not cover the Levemir so the pharmacy sent a form to the facility dated 11/13/17 to get the order changed to Lantus. -The pharmacy sent a form to change the morning dose of Levemir to Lantus. -It did not appear a form to change the bedtime dose of Levemir to Lantus was sent. -He did not know why a form for the bedtime dose	D 344		

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D 344	Continued From page 4 was not sent. -The bedtime dose of Levemir should have been switched to Lantus at the same time the morning dose of Levemir was changed to Lantus. -There was no order on file to discontinue the bedtime dose of Levemir. -There was no order on file to clarify if the resident should have continued to receive a long-acting insulin at bedtime. Interview with Resident #4 on 03/14/18 at 5:23 p.m. revealed: -She was diabetic and got insulin before meals. -She used to get insulin at bedtime but they stopped giving it to her at bedtime a few months ago. -She did not know why she no longer received insulin at bedtime. -Her primary care provider had not said anything about discontinuing the bedtime insulin. -Her blood sugar had been running higher than it used to. Attempted telephone interview with Resident #4's primary care provider (PCP) on 03/14/18 at 4:10 p.m. was unsuccessful. Review of a clarification order faxed to the facility on 03/15/18 for Resident #4 revealed an order to discontinue the Levemir 18 units at bedtime.	D 344		
{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:	{D 358}	Med passes will be supervised by facility RCC and/or administrator - Med Tech Supervisor. Patty Matthews, Corp trainer has conducted inservices	

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{D 358}	Continued From page 5 (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 TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 4 residents (#1, #4) observed during the medication passes including errors with timing of insulin administration (#1, #4) and an antibiotic ear drop (#1); and for 3 of 5 residents (#1, #2, #4) sampled including errors with sliding scale insulin (#1, #2) and failure to hold scheduled insulin for low blood sugar parameters and when resident did not eat meals (#1, #4). The findings are: 1. The medication error rate was 10% as evidenced by the observation of 3 errors out of 28 opportunities during the 8:00 a.m. and 11:30 a.m. / 12:00 p.m. medication passes on 03/14/18. a. Review of Resident #4's current FL-2 dated 11/01/17 revealed diagnoses included dementia, diabetes mellitus, hypertension, depression, hypothyroidism, and ear infection. Review of Resident #4's physician's orders revealed an order dated 03/05/18 for Humalog	{D 358}	for all medtecns on 3.15.18 c̄ hands on demonstration. Pharmacy has also conducted an inservice on 3.23.18 @ 10am on med Administration for all medtecns. On 3.16.18 @ 6am, all med pass were being passed off of paper mar c̄ proper training of new procedures. All facility medtecns will be re-evaluated for competency. Ongoing education/ supervision by RCC admin/med tech supervisor and pharmacy staff. Facility will replace medtecns as needed based upon competency evaluations.	

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{D 358}	Continued From page 6 insulin inject 3 units 3 times daily with breakfast, lunch, and dinner; hold if blood sugar is less than (<) 110 or if resident does not eat. (Humalog is rapid-acting insulin used to lower blood sugar. The manufacturer recommends Humalog be taken within 15 minutes before eating a meal.) Review of Resident #4's March 2018 medication administration record (MAR) revealed: -There was an entry for Humalog inject 3 units with breakfast, lunch, and dinner; hold for blood sugar < 110 or resident does not eat that meal. -Humalog was scheduled to be administered at 7:30 a.m., 11:30 a.m., and 5:00 p.m. -The resident's blood sugar ranged from 123 - 330 from 03/01/18 - 03/13/18. Interview with the medication aide (MA) on 03/14/18 at 12:01 p.m. revealed: -Lunch was usually served at 12:30 p.m. -She usually started checking fingerstick blood sugars (FSBS) and administering insulin around 12:00 noon each day. Observation during the medication pass on 03/14/18 revealed: -Resident #4 was in her room. -The MA checked Resident #4's blood sugar at 12:13 p.m. and it was 165. -The MA administered 3 units of Humalog insulin to the resident at 12:15 p.m. Observation of Resident #4 on 03/14/18 revealed: -The resident was served lunch at 12:41 p.m., 26 minutes after receiving Humalog, a rapid-acting insulin. -The resident did not receive Humalog insulin with the meal as ordered. -The resident ate approximately 75% of her lunch meal.	{D 358}	RCC will routinely check mars for accuracy and provide any needed training per mar checks. RCC will ensure all mars are accurate according to the physician's order and medications are given to residents according to such orders. Any orders not clear of its intent will be clarified by the attending physician. All will be supervised by RCC, admin / RCC superv, manager.	3.16.18

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{D 358}	Continued From page 7 Interview with the MA on 03/14/18 at 1:10 p.m. revealed: -The FSBS and insulin usually "popped" up on the electronic MARs at 12:00 noon. -The lunch meal was usually served on time at 12:30 p.m. and they usually waited to serve the meal until all residents were in the dining room. -She thought the facility's policy was to administer insulin 15 to 20 minutes prior to the meal. -She had not noticed the order for Resident #4's insulin was to administer it with meals. -The resident sometimes refused to eat meals but she had no way of knowing if the resident was going to eat the meal before she administered the insulin. Interview with the Care Coordinator (CC) on 03/14/18 at 1:30 p.m. revealed: -The MAs had been trained on administering insulin and the facility's policy. -The facility's policy was to administer insulin ordered with meals right before the resident went into the dining room with the meal already on the table. -Lunch was usually served at 12:30 p.m. but it sometimes ran late. -The MAs should wait until the food was on the table and then administer the insulin just prior to Resident #4 entering the dining room to eat. -The MAs should ask the resident if she was going to eat because Resident #4 had been skipping some meals recently. Interview with Resident #4 on 03/14/18 at 5:23 p.m. revealed: -She was diabetic and got insulin before meals. -She usually got insulin about 30 minutes before she received her meals. -She did not recall any times when she felt her	{D 358}		

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{D 358}	Continued From page 8	{D 358}		

blood sugar had gotten too low while she was waiting to receive her meals.
-Her blood sugar had been running higher than it used to.

Attempted telephone interview with Resident #4's primary care provider (PCP) on 03/14/18 at 4:10 p.m. was unsuccessful.

b. Review of Resident #1's current FL-2 dated 06/12/17 revealed diagnoses included vascular dementia, diabetes, hypertension, cerebrovascular accident, depression, hyperlipidemia, neuropathy, and atrial fibrillation.

Review of Resident #1's physician's orders revealed an order dated 09/18/17 for Novolog insulin inject 5 units 3 times daily with meals; hold if blood sugar is less than (<) 110 or if resident does not eat. (Novolog insulin is rapid-acting insulin used to lower blood sugar. The manufacturer recommends eating a meal within 5 to 10 minutes after the injection.)

Review of Resident #1's March 2018 medication administration record (MAR) revealed:
-There was an entry for Novolog inject 3 units with meals; hold for blood sugar < 110 or resident does not eat that meal.
-Novolog was scheduled to be administered at 8:00 a.m., 12:00 p.m., and 5:00 p.m.
-The resident's blood sugar ranged from 52 - 430 from 03/01/18 - 03/14/18.

Interview with the medication aide (MA) on 03/14/18 at 12:01 p.m. revealed:
-Lunch was usually served at 12:30 p.m.
-She usually started checking fingerstick blood sugars (FSBS) and administering insulin around 12:00 noon each day.

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{D 358}	Continued From page 9	{D 358}		

Observation during the medication pass on 03/14/18 revealed:
-Resident #1 was in her room.
-The MA checked Resident #1's blood sugar at 12:20 p.m. and it was 184.
-The MA did not ask the resident if she was going to eat lunch.
-The MA administered 8 units of Novolog insulin to the resident at 12:24 p.m.

Observation of Resident #1 on 03/14/18 revealed:
-The resident was served lunch at 12:41 p.m., 17 minutes after receiving Novolog, a rapid-acting insulin.
-The resident did not receive Novolog insulin with the meal as ordered.
-The resident ate approximately 90% of her lunch meal.

Interview with the MA on 03/14/18 at 1:10 p.m. revealed:
-The FSBS and insulin usually "popped" up on the electronic MARs at 12:00 noon.
-The lunch meal was usually served on time at 12:30 p.m. and they usually waited to serve the meal until all residents were in the dining room.
-She thought the facility's policy was to administer insulin 15 to 20 minutes prior to the meal.
-She had not noticed the order for Resident #1's insulin was to administer it with meals.
-Resident #1 usually ate her meals.

Interview with the Care Coordinator (CC) on 03/14/18 at 1:30 p.m. revealed:
-The MAs had been trained on administering insulin and the facility's policy.
-The facility's policy was to administer insulin ordered with meals right before the resident went into the dining room with the meal already on the

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table.
-Lunch was usually served at 12:30 p.m. but it sometimes ran late.
-The MAs should wait until the food was on the table and then administer the insulin just prior to Resident #1 entering the dining room to eat.

Based on observations, interviews, and record reviews, Resident #1 was not interviewable.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 03/14/18 at 4:10 p.m. was unsuccessful.

c. Review of Resident #1's physician's orders revealed an order dated 03/05/18 for Cipro Otic 0.2% 1 drop in both ears 3 times a day for 2 weeks for ear infection. (Cipro Otic is an antibiotic ear drop used to treat ear infections.)

Review of Resident #1's March 2018 medication administration record (MAR) revealed:
-There was an entry for Cipro Otic 0.2% solution, instill 1 drop into both ears 3 times a day for 14 days.
-Cipro Otic was scheduled to be administered at 8:00 a.m., 2:00 p.m., and 8:00 p.m.
-The first dose of Cipro Otic was documented as administered at 2:00 p.m. on 03/06/18.

Observation of the medication pass on 03/14/18 at 8:56 a.m. revealed:
-Resident #1 was sitting straight up on her bed.
-The medication aide (MA) did not ask the resident to tilt her head or to lie down prior to administering 1 drop of Cipro Otic in the left ear and then putting a piece of cotton ball in the left ear.
-When the MA asked the resident if she felt the ear drop go into her ear, the resident stated, "No".

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{D 358}	Continued From page 11 -The MA never asked the resident to tilt her head so the drop could go into the resident's ear canal. -The MA immediately pressed the ear dropper container 3 times with the tip down in the resident's right ear. -The resident was still sitting straight up on the bed and the MA never asked the resident to tilt her head so the ear drops could go down into the resident's ear canal. -The MA put a piece of cotton in the resident's right ear. Interview with the MA on 03/14/18 at 1:00 p.m. revealed: -She had training on how to administer ear drops but she could not recall when. -She was aware she was supposed to have the resident tilt her head prior to administering the ear drops but the resident was impatient. -She was not aware the resident's head should be tilted or the resident should remain lying on her side for 5 minutes after the medication was administered in each ear. Interview with the Care Coordinator (CC) on 03/14/18 at 1:27 p.m. revealed: -She and the MAs had been trained on how to administered ear drops but she could not recall when. -They were supposed to have the resident tilt their head and then administer the required number of drops. -Then they were supposed to put a cotton ball in the resident's ear and have the resident keep their head tilted to the side. -She could not recall how long the resident's head should remain tilted after the ear drop was administered. -If a resident would not tilt their head, they could have the resident to lie down on their side.	{D 358}		

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{D 358}	Continued From page 12	{D 358}		

-She would arrange for the MAs to have refresher training on how to properly administer ear drops.

2. Review of Resident #4's current FL-2 dated 11/01/17 revealed diagnoses included dementia, diabetes mellitus, hypertension, depression, hypothyroidism, and ear infection.

Review of Resident #4's physician's orders revealed:
-There was an order dated 11/12/17 for Novolog insulin 3 units at breakfast, 6 units with lunch, and 6 units at dinner. (Novolog insulin is rapid-acting insulin used to lower blood sugar. The manufacturer recommends eating a meal within 5 to 10 minutes after the injection.)
-There was an order dated 11/13/17 to change the Novolog to Humalog insulin due to the resident's insurance not covering Novolog insulin. (Humalog is rapid-acting insulin used to lower blood sugar. The manufacturer recommends Humalog be taken within 15 minutes before eating a meal.)
-There was an order dated 11/13/17 to hold Humalog with meals if the fingerstick blood sugar (FSBS) was less than (<) 110 or if the resident does not eat meal.
-There was an order dated 03/05/18 for Humalog insulin inject 3 units 3 times daily with breakfast, lunch, and dinner; hold if blood sugar is < 110 or if resident does not eat.

Review of Resident #4's January 2018 nurses' notes revealed:
-01/05/18 (2pm - 10pm): The resident refused to eat dinner.
-01/15/18 (2pm - 10pm): The resident refused to eat dinner.
-01/23/18 (2pm - 10pm): The resident refused to eat supper.

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{D 358}	Continued From page 13 -01/25/18: The resident refused to eat her lunch today. The Care Coordinator and the owner had a meeting with the resident about the importance of eating her meals. The resident stated she was on a "hunger strike". -01/25/18 (2pm - 10pm): The resident refused to eat dinner because her mouth was hurting. -01/26/18 (8:10 a.m.): The resident refused to eat her breakfast. She would only take her medications, drink coffee, and smoke. -01/26/18 (2pm - 10pm): The resident refused to eat dinner, she claimed she was fasting for the next several days. Staff explained to her the importance of eating supper. -01/28/18 (7am): The resident refused breakfast. Review of Resident #4's January 2018 medication administration record (MAR) revealed: -There was an entry for Humalog inject 3 units at breakfast, 6 units with lunch, and 6 units at dinner (hold if FSBS < 110 or resident does not eat that meal). -Humalog was scheduled to be administered at 8:00 a.m., 12:00 p.m., and 5:00 p.m. -The resident's FSBS was documented as < 110 on 5 occasions in January 2018. -The resident's FSBS was 102 on 01/11/18 at 12:00 p.m., 99 on 01/17/18 at 5:00 p.m., 62 on 01/20/18 at 5:00 p.m., 103 on 01/23/18 at 5:00 p.m., and 78 on 01/30/18 at 5:00 p.m. -Humalog insulin was documented as administered on all 5 occasions the FSBS was < 110 instead of held as ordered. -Staff documented Humalog insulin was administered on 8 occasions when staff had documented in the nurses' notes that the resident did not eat the meal instead of holding the insulin as ordered. -Humalog was documented as administered when the resident did not eat breakfast on	{D 358}		

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01/26/18 and 01/28/18.
-Humalog was documented as administered when the resident did not eat lunch on 01/25/18.
-Humalog was documented as administered when the resident did not eat dinner on 01/05/18, 01/15/18, 01/23/18, 01/25/18, and 01/26/18.
-The resident's FSBS ranged from 62 - 361 from 01/01/18 - 01/31/18.

Review of Resident #4's February 2018 MAR revealed:
-There was an entry for Humalog inject 3 units at breakfast, 6 units with lunch, and 6 units at dinner (hold if FSBS < 110 or resident does not eat that meal).
-Humalog was scheduled to be administered at 8:00 a.m., 12:00 p.m., and 5:00 p.m.
-The resident's FSBS was documented as < 110 on 4 occasions when insulin should have been held in February 2018.
-The resident's FSBS was 98 on 02/01/18 at 8:00 a.m., 90 on 02/12/18 at 12:00 p.m., 72 on 02/21/18 at 5:00 p.m., and 96 on 02/27/18 at 5:00 p.m.
-Humalog insulin was documented as administered on all 4 occasions the FSBS was < 110 instead of held as ordered.
-The resident's FSBS ranged from 72 - 487 from 02/01/18 - 02/28/18.

Review of Resident #4's March 2018 MAR revealed the resident's FSBS ranged from 123 - 330 from 03/01/18 - 03/13/18 and Humalog would not have been required to be held.

Interview with a medication aide (MA) on 03/14/18 at 1:10 p.m. revealed:
-If insulin or any other medication was held, the MAs would documented it as withheld per doctor's orders on the MAR.

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{D 358}	Continued From page 15 -She did not recall holding Humalog insulin for Resident #4. -She usually administered insulin 15 to 20 minutes prior to the meal. -Resident #4 sometimes refused to eat meals but she had no way of knowing if the resident was going to eat the meal before she administered the insulin. Interview with a second MA on 03/14/18 at 1:18 p.m. revealed: -Resident #4 sometimes ate her meals and sometimes she did not. -The MAs were supposed to hold the resident's insulin and document it as held if the resident did not eat. -About a month ago, the Care Coordinator (CC) told the MA that staff was not documenting that the insulin was being held as ordered. -She started documented "withheld per doctor's orders" from the drop down menu after that. Interview with a third MA on 03/14/18 at 5:14 p.m. revealed: -If she held a dose of any medication, it would be documented as "withheld per doctor's orders" on the MAR. -She did not recall holding any insulin for Resident #4. -Resident #4 skipped meals sometimes. -She did not know if Resident #4 was going to eat the meal so she usually waited for the food to be available and ready before she administered the insulin. Interview with the Care Coordinator (CC) on 03/14/18 at 1:30 p.m. revealed: -The MAs had been trained on administering insulin and the facility's policy. -The facility's policy was to administer insulin	{D 358}		

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ordered with meals right before the resident went into the dining room with the meal already on the table.
-The MAs should wait until the food was on the table and then administer the insulin just prior to Resident #4 entering the dining room to eat.
-The MAs should ask the resident if she was going to eat because Resident #4 had been skipping some meals recently.
-If Resident #4 was not going to eat or if the FSBS was < 110, the insulin should be held as ordered.
-She had not noticed that the MAs were not holding the insulin when the resident did not eat or if the resident's FSBS was < 110.
-She checked the MARs sometimes but there was no set system to review the MARs to assure medication orders were being followed.

Interview with Resident #4 on 03/14/18 at 5:23 p.m. revealed:
-She was diabetic and got insulin before meals.
-She usually got insulin about 30 minutes before she received her meals.
-She recently had an abscess in her jaw and her appetite had not been good.
-She did not recall her insulin being held if she did not eat her meals.
-She did not recall any times when she felt her blood sugar had gotten too low while she was waiting to receive her meals.
-Her blood sugar had been running higher than it used to.

Attempted telephone interview with Resident #4's primary care provider (PCP) on 03/14/18 at 4:10 p.m. was unsuccessful.

3. Review of Resident #1's current FL-2 dated 06/12/17 revealed a diagnoses included vascular

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{D 358}	Continued From page 17 dementia, diabetes and atrial fibrillation, hypertension, and depression. a. Review of Resident #1's physician's orders dated 02/16/18 revealed: -There was an order for Coumadin 3.5mg on Mondays and Tuesdays and 3 mg on Wednesdays, Thursdays, Fridays, Saturdays and Sundays (Coumadin is a medication used to thin the blood. INR is a lab used to determine the effectiveness of the Coumadin and is usually recommended to be between 2 and 3.) -On 02/16/18, the resident's INR was 3.1, recheck the INR on 02/23/18. -There was an order dated 02/23/18 to hold the Coumadin for 3 days, recheck the INR in 3 days on 02/27/18, -On 02/23/18 the residents INR was 3.7 (above therapeutic range) Review of Resident #1's electronic medication administration record (e-MAR) for February 2018 revealed: -There was an entry for Coumadin 3mg take one tablet daily. -There was a second entry for Coumadin 1mg tag take ½ tab (.5mg) on Monday's and Tuesday's. -The order to hold Coumadin was not included on the e-MAR. -Coumadin 3mg was initialed as administered every day in the month of February. Interview with the Medication Aide (MA) on 03/14/18 at 1:07 p.m. revealed: -If there was a hold on a medication the screen for that medication will be gray and you cannot initial it. -She did not remember the Coumadin being held in February 2018. -If she initialed the Coumadin she would have	{D 358}		

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administered it.
-She thought the pharmacy entered the hold orders on the e-MAR for medications to be held.

Interview with a second MA on 03/15/18 at 10:45 a.m. revealed:
-She did not remember holding the Coumadin for Resident #1.
-If she gave a medication it would be initialed on the e-MAR.

Interview with the Care Coordinator on 03/14/18 at 1:40 p.m. revealed:
-She usually tracked the INRs for changes but not always.
-The facility's pharmacy puts medications on hold on the e-MAR.
-She did not always see all the new orders, sometimes they were faxed to the pharmacy from the doctor's office and sometimes the facility faxed them.
-She was not sure if the order from 02/23/18 was faxed to the pharmacy.

Telephone Interview with a pharmacist from the facility's pharmacy on 03/14/18 at 4:35 p.m. revealed:
-As a general rule, the pharmacy did not put hold orders in the e-MAR.
-The facility can temporarily enter orders including hold orders into the e-MAR.
-The pharmacy expected the facility to enter hold orders in the e-MAR.

Attempted telephone interview on 03/14/18 at 4:10 p.m. and on 03/15/18 at 11:00 a.m. with Resident #1's primary care provider (PCP) was unsuccessful.

Attempted interview with Resident #1 on 03/14/18

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{D 358}	Continued From page 19 at 5:00 p.m. revealed the resident was not interviewable. Review of Resident #1's physicians orders revealed: -Resident #1's next INR was drawn on 02/27/18 and the results were 1.4 (below therapeutic range) -There was an order dated 02/27/18 for Coumadin 3mg daily. b. Review of a physician's order for Resident #1 dated 08/21/17 revealed an order for Novolog 8 units inject subcutaneous with meals. Hold parameters if FSBS is less than 110 or if resident does not eat that meal. (Novolog is a fast acting insulin used to lower blood sugar.) Review of Resident #1's electronic medication administration record (e-MAR) for January 2018 revealed: -There was an entry for Novolog 8 units with meals hold if FSBS is less than 110 or does not eat. -There were 13 ocassions in January 2018 when the resident's FSBS was less than 110 and the Novolog should have been held but was documented as administered. -The FSBS on 01/2/18 at 8:00 a.m. was 81, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/4/18 at 12:00 p.m. was 91, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/6/18 at 12:00 p.m. was 84, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/7/18 at 8:00 a.m. was 91, there was documentation that 8 units of Novolog were administered.	{D 358}		

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{D 358}	Continued From page 20 -The FSBS on 01/8/18 at 8:00 a.m. was 91, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/12/18 at 8:00 a.m. was 90, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/13/18 at 8:00 a.m. was 83, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/15/18 at 8:00 a.m. was 104, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/18/18 at 8:00 a.m. was 104, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/19/18 at 8:00 a.m. was 102, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/20/18 at 8:00 a.m. was 71, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/22/18 at 8:00 a.m. was 74, there was documentation that 8 units of Novolog were administered. -The FSBS on 01/24/18 at 8:00 a.m. was 91, there was documentation that 8 units of Novolog were administered. -Resident #4's FSBS range was 74-538 in the month of January 2018. Review of Resident #1's e-MAR for February 2018 revealed: -There was an entry for Novolog 8 units with meals hold if FSBS is less than 110 or does not eat. -There were 3 occasions in February 2018 when the resident's FSBS was less than 110 and Novolog should have been held but was documented as administered. -The FSBS on 02/22/18 at 8:00 a.m. was 106,	{D 358}		

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{D 358}	Continued From page 21 there was documentation that 8 units of Novolog were administered. -The FSBS on 02/26/18 at 12:00 p.m. was 76, there was documentation that 8 units of Novolog were administered. -The FSBS on 02/27/18 at 12:00 p.m. was 89, there was documentation that 8 units of Novolog were administered. -Resident #1's FSBS range was 58-456 in the month of February 2018. Review of Resident #1's e-MAR for March 2018 revealed: -There was an entry for Novolog 8 units with meals hold if FSBS is less than 110 or does not eat. -There were 2 occasions from March 1-13 2018 when the residents FSBS was less than 110 and Novolog should have been held but was documented as administered. -The FSBS on 03/2/18 at 8:00 a.m. was 102, there was documentation that 8 units of Novolog were administered. -The FSBS on 03/7/18 at 8:00 a.m. was 107, there was documentation that 8 units of Novolog were administered. -Resident #1's FSBS range was 52-382 from March 1-13 2018. Interview with a Medication Aide (MA) on 03/14/18 at 10:45 a.m. revealed: -He did not always read the whole order each time he had to administer insulin to Resident #1. -He had started reading the whole insulin order today (03/14/18) after the Care Coordinator talked with him about the insulin orders. -He had administered insulin to Resident #1 when it should have been held because he had not read the whole order.	{D 358}		

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Interview with a second MA on 03/14/18 at 5:20 p.m. revealed:
-She knew that insulin dropped the blood sugar.
-She was not sure why she had initialed giving insulin when a blood sugar was lower than 110.
-"If I initialed a medication, then I gave it."

Attempted telephone interview on 03/14/18 at 4:10 p.m. and on 03/15/18 at 11:00 a.m. with Resident #1's Primary Care Provider was unsuccessful.

c. Review of a current physician's order dated 06/12/17 for Resident #1 revealed an order to check Finger Stick Blood Sugar (FSBS) with meals and administer Novolog insulin according to the following sliding scale: less the 200 = 0 ; 201-250 = 1 unit: 251-300 = 2 units; 301-350 = 3 units; 351-400 = 4 units; 401-450 = 5 units. (Novolog is a rapid acting insulin used to lower blood sugar.)

Review of Resident #1's January 2018 electronic medication administration record (e-MAR) revealed:
-There was an entry for Novolog insulin according to the following sliding scale: less than 200 = 0; 201-250 = 1 unit; 251-300 = 2 units; 301-350 = 3 units; 351-400 = 4 units;401-450 = 5 units.
-The FSBS was 344 on 01/21/18 at 5:00 p.m. and would have required 3 units of insulin but there was an entry 5 units were documented as administered.
-The FSBS was 275 on 01/25/18 at 12:00 p.m. and would have required 1 unit of insulin but 4 units were documented as administered.
-The fasting blood sugars ranged from 74-538 for the month of January 2018.

Interview with a Medication Aide (MA) on

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03/14/18 at 10:45 a.m. revealed:
-He was hired as a MA on 06/15/17.
-He was not always reading the whole order each time he had to administer insulin to Resident #1.
-He had administered the amount of insulin he documented on the e-MAR.
-He thought he remembered the amount of insulin the resident should receive without reading the order each time.

Attempted interview with Resident #1 on 03/14/18 at 5:00 p.m. revealed the resident was not interviewable.

Interview with the Care Coordinator on 03/14/18 at 1:20 p.m. revealed:
-She did not usually check the MARs for accuracy.
-She expected the MA's to read the insulin sliding scale orders before administering the sliding scale insulin dose.

Attempted telephone interview on 03/14/18 at 4:10 p.m. and on 03/15/18 at 11:00 a.m. with Resident #1's Primary Care Provider (PCP) was unsuccessful.

4. Review of Resident #2's FL-2 dated 7/24/17 revealed:
- Diagnoses included vascular dementia, atrial fibrillation, hypothyroidism and hypertension.
-There was orders for diabetic glucose testing 2 times a day at 8:00am and 5:00pm.
-There was an order for Lantus insulin, inject 10 units subcutaneous at bedtime (Lantus is used to lower blood sugar).
-There was an order forTradjenta 5mg by mouth 1 time a day (Tradjenta is used to lower blood sugar).

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{D 358}	Continued From page 24 Review of a local hospital discharge summary dated 3/2/18 revealed: -Resident #2's admission diagnoses included diabetes mellitus 2, uncontrolled and urinary tract infection. -The resident's initial glucose (blood sugar) was 791 and today [2/28/18] her glucose was 77 (target glucose ranges are 70 - 130 for diabetics) and her A1c level was 10.1 (typical A1c level for diabetic is 5). -The [resident] should not be on an oral hypoglycemic agent, but should be on regular insulin with blood sugar checks 4 times a day. -Contact the primary medical provider for an appointment. Review of Resident #2's primary medical provider's visit report dated 3/5/18 revealed orders to discontinue Tradjenta and to start Humalog insulin 4 units with meals, hold if blood glucose is less than 120 or if patient does not eat that meal.(Humalog is a fast acting insulin used to treat used to lower blood sugars). Review of Resident #2's medication administration record (MAR) for March 2018 revealed: -There were preprinted instructions to check blood sugars (BS) twice a day before breakfast and supper at 8:00am and 5:00pm. BS values were documented as checked at 8:00am and 5:00pm. -There were preprinted instructions for Humalog insulin, inject 4 units subcutaneously three times a day with meals. Hold if BS was less than 120 or if resident does not eat meal. The scheduled administration times were 8:00am, 2:00pm and 8:00pm. -Humalog insulin (4 units) was documented as administered at 8:00am, 2:00pm and 8:00pm.	{D 358}		

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{D 358}	Continued From page 25	{D 358}		

Interview with the facility's Care Coordinator on 3/14/18 at 9:20am revealed:
-Resident #2's Humalog insulin was ordered to be administered with meals and should have been administered with meals if BSs were greater than 120 and if she ate the meal.
-The meal times were 7:30am (breakfast) 12:30pm (lunch), and 5:30pm (dinner).
-The resident's insulin administration times should be at 7:30am, 12:30pm and 5:30pm not 8:00am, 2:00pm or 8:00pm. -The resident's BS checks should be done before insulin administration.
-The administration times on the resident's MAR should have been changed and a new order for BS should have been obtained from the primary care provider. The MAs did not report any problems with the insulin or BS check times and she had not checked the MARs since the new order was received.
-The Care Coordinator or the MAs were responsible for obtaining clarification orders and checking the MARS for accuracy.
-She will follow-up with the medical provider and obtain new orders for BS checks and change administration times for the insulin.

Interview with a 2nd shift medication aide on 3/14/18 at 4:15pm revealed:
-She worked 2nd shift and administered insulin to Resident #2.
-The resident ate dinner at 5:30pm but her Humalog insulin was administered at 8:00pm.
-The MA checked the resident's BS at 5:00pm but did not check the resident's BS before administering the insulin at 8:00pm. If the Resident's BS was 120 or greater at 5:00pm, she administered 4 units of Humalog insulin at 8:00pm.

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{D 358}	Continued From page 26	{D 358}		

-The MA was aware if a medication, including insulin, was ordered to be administered with meals, the resident should be eating a meal before the medication was administered but she followed the instructions on the MAR instead.
-The MA did not clarify the MAR with the pharmacy or primary medical provider.

Interview with the facility's pharmacist on 3/14/18 at 4:33pm revealed:
-Normally when a new medication or treatment was entered into the electronic MARS by the pharmacy, administration times were entered.
-If a medication, including insulin, was ordered with meals, the administration times would be meal times.
-The resident's Humalog administration times should have been her meal times (7:30am, 12:30pm and 5:30pm).
-The facility should have changed the times to 7:30am, 12:30pm and 5:30pm or contacted the pharmacy to change the times.

Review of a clarification order dated 3/15/18 revealed an order to start fingersticks for blood sugar 3 times a day before meals at 7:00am, 12:00pm and 5:00pm.

Review of the resident's March 2018 MAR revealed the Humalog insulin administration times had been changed to 7:30am, 12:30pm and 5:30pm.

Resident #2's primary medical provider was not available for interview.

Based on observation, record review and interviews, Resident #2 was not interviewable.

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{D 358}	Continued From page 27 The facility did not administer medications as ordered for 3 diabetic residents (Residents #1, 2 and 4) with orders for insulin, which can cause unstable blood sugars. The facility did not hold a blood thinner as ordered for Resident #1 which can put the resident at risk for bleeding. The facility's continued failure to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. ________________ Review of the facility's Plan of Protection dated 03/14/18 revealed: -Medication passes will be supervised by the facility's Care Coordinator (CC) and/or Administrator and/or Medication Aide (MA) Supervisor. -The Corporate Trainer will conduct in-service for all MAs on 03/15/18 with hands on demonstration. -Pharmacy will conduct an in-service on 03/23/18 at 10:00 a.m. on medication administration for all MAs. -Beginning 03/16/18 at 6:00 a.m. medication pass, the facility will begin using paper MARs with proper training of new procedure. -All facility MAs will be re-evaluated for competency. -Ongoing education / supervision by CC, Administrator, MA Supervisor, and pharmacy staff. -Replace MAs as needed based upon competency evaluations. -CC will routinely check MARs for accuracy and provide training as needed per MAR checks. -CC will ensure all MARs are accurate according to the physician's order and medications are given to residents according to such orders. -Any order not clear of its intent will be clarified by	{D 358}		

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{D 358}	Continued From page 28 the attending physician. -All will be supervised by CC, Administrator, MA Supervisor, and Manager. -This will start Friday, 03/16/18.	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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 observations, interviews, and record reviews, the facility failed to assure medication administration records were accurate for 2 of 5 residents (#1, #4) sampled including inaccurate documentation of scheduled and sliding scale insulin (#1) and inaccurate documentation of a	D 367	RCC will assure that all orders are written properly and any unsure orders will be clarified by the MD and sent to the pharmacy from proper input on the mars. RCC will assure that all medtecns are documenting according to the given orders. RCC will continue to provide any training needed to assure accuracy. This	

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D 367	Continued From page 29 topical wound medication being administered orally and being administered when it was unavailable to be administered (#4). The findings are: 1. Review of Resident #4's current FL-2 dated 11/01/17 revealed diagnoses included dementia, diabetes mellitus, hypertension, depression, hypothyroidism, and ear infection. Review of a physician's order dated 03/09/18 for Resident #4 revealed an order for Medihoney gel, 1ml topical daily. (Medihoney is a topical medication used to treat hard to heal wounds and burns.) Review of Resident #4's March 2018 medication administration record (MAR) revealed: -There was an entry for Medihoney 1ml by mouth daily. -Staff documented Medihoney had been administered by mouth to Resident #4 from 03/10/18 - 03/13/18 (4 days). -There was no entry on the MAR for the Medihoney to be applied topically as ordered. Observation of medications on hand for Resident #4 on 03/13/18 revealed there was no Medihoney in the medication cart for the resident. Interview with a medication aide (MA) on 03/13/18 at 5:30 p.m. revealed: -He did not remember if he gave the Medihoney to Resident #4 even though he initialed it on the MAR. -He thought the Medihoney might be a cough syrup. -If he gave it, he would have administered it by mouth because that was the instructions on the	D 367	Will be supervised by the Admin manager. Completed by 3-16-18 [signature] 4/16/18	

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D 367	Continued From page 30 MAR. -He could not find any in the medication cart. Interview with the Care Coordinator (CC) on 03/13/18 at 5:35 p.m. revealed: -She was not aware the Medihoney was not available in the facility. -She just found a slip of paper from the pharmacy on the desk at the nurses' station indicating the Medihoney was temporarily out of stock. -She was not aware the instructions on the MAR indicated to administer the Medihoney by mouth instead of topically as ordered. -The pharmacy usually entered new orders into the electronic MAR system. -She sometimes checked the MARs for accuracy but there was no set system for checking them. -The MAs should have documented that the Medihoney was unavailable due to waiting on pharmacy on the MAR. -The MAs have been trained on how to document and they were not supposed to document a medication was administered if it was not. -The resident went to a wound clinic last week for a wound on her foot and that was when she received the order for Medihoney. -She would notify the wound clinic that the Medihoney had not been applied to the resident's wound yet. -She would check with the pharmacy about correcting the instructions on the MAR for the Medihoney. Review of a pharmacy communication slip for Resident #4 revealed: -There was a medication label affixed to the slip of paper dated 03/10/18 with Medihoney apply 1ml to affected area every day printed on the label. -There was a note on the slip indicating	D 367		

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D 367	Continued From page 31 Medihoney was temporarily out of stock and would be sent on or before 03/13/18. Telephone interview with a pharmacist from the facility's primary pharmacy on 03/14/18 at 4:34 p.m. revealed: -They received the order dated 03/09/18 for Medihoney apply 1ml topically once a day on 03/10/18 at 2:12 a.m. -The pharmacy typically entered new orders into the e-MAR system but the facility could also enter orders temporarily if needed. -The Medihoney should be administered topically, not by mouth. -It appears the order for Medihoney was originally entered incorrectly into the e-MAR system but was changed by pharmacy staff prior to the medication being sent to the facility on 03/13/18. -There was a delay in sending the Medihoney because they were trying to determine if they could use the paste instead of gel. -It may have also been delayed if the pharmacy had to order the Medihoney from their supplier. -They received a call from the facility on 03/12/18 to use the paste. -The Medihoney paste was delivered to the facility on 03/13/18. Interview with Resident #4 on 03/13/18 at 10:30 a.m. revealed: -She had a wound on her foot that a home health nurse was dressing but she was not sure how often. -She did not recall facility staff applying anything to her foot wound. Interview with the CC on 03/14/18 at 11:00 a.m. revealed: -Resident #4's Medihoney came in the pharmacy tote last night and was on hand in the medication	D 367		

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D 367	Continued From page 32 cart. -She received a revised order for the Medihoney dated 03/09/18 for it to be applied 3 times a week. -A home health nurse would be applying the Medihoney. Review of an order dated 03/09/18 for Resident #4 revealed an order for Medihoney to be applied to left plantar foot 3 times per week. 2. Review of Resident #1's current FL-2 dated 06/12/17 revealed diagnoses included vascular dementia, hypertension, diabetes, hyperlipidemia, neuropathy and atrial fibrillation. Review of Resident #1's physician's order dated 06/12/17 revealed an order for sliding scale Novolog insulin check blood sugar with meals. For readings under 200= 0 units, 201-250 = 1 unit, 251-300 = 2 units, 301-350 = 3 units, 351-400 = 4 units, 401-450 = 5 units. (Novolog is a rapid acting insulin used to lower blood sugar) Review of Resident #1's physician's order dated 08/17/17 revealed there was an order for Novolog insulin inject 8 units subcutaneous with meals 8:00 a.m.-12:00 p.m.-5:00 p.m. hold parameter if finger stick blood sugar is less than 110 or if resident does not eat that meal. Review of Resident #1's January 2018 electronic medication administration record (e-MAR) revealed: -There was an entry for Novolog inject 8 units with meal, hold if FSBS is less than 110 or the resident does not eat the meal. -The routine Novolog was scheduled to be administered at 8:00 a.m., 12:00 p.m. and 5:00 p.m.	D 367		

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-There was an entry for Novolog sliding scale with meals according to the following scale: less than 220 = 0 units, 201-250 = 1 unit, 251-300 = 2 units, 301-350 = 3 units, 401- 450 = 5 units.
-The Novolog sliding scale was scheduled to be administered at 8:00 a.m., 12:00 p.m. and 5:00 p.m.
-The routine Novolog was documented as administered at all times except held on 01/30/18 at 12:00 p.m. per doctor's order.
-Eight units of Novolog were documented as administered on 20 occasions under the entry for the Novolog sliding scale insulin.
-The resident's blood sugar was less than 200 on 12 occasions the 8 units were documented for the Novolog sliding scale.
-The Novolog sliding scale did not have any parameters that would have required 8 units of insulin to be administered.
-The routine 8 units of Novolog was also documented as administered on those 12 occasions, which appeared the resident received 16 units of Novolog on those occasions.
-No sliding scale would be required on those occasions.
-Staff double documented the routine Novolog insulin administration under the routine Novolog entry and under the sliding scale Novolog entry on the MAR.
-The resident's FSBS range for January 2018 was 74-538.

Review of Resident #1's February 2018 e-MAR revealed:
-There was an entry for Novolog inject 8 units with meal, hold if FSBS is less than 110 or the resident does not eat the meal.
-The routine Novolog was scheduled to be administered at 8:00 a.m., 12:00 p.m. and 5:00 p.m.

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D 367	Continued From page 34 -There was an entry for Novolog sliding scale with meals according to the following scale: less than 220 = 0 units, 201-250 = 1 unit, 251-300 = 2 units, 301-350 = 3 units, 401- 450 = 5 units. -The Novolog sliding scale was scheduled to be administered at 8:00 a.m., 12:00 p.m. and 5:00 p.m. -The routine Novolog was documented as administered all times except for held on 9 occasions per doctor's order when the FSBS was less than 110. -Eight units of Novolog was documented as administered on 15 occasions under the entry for the Novolog sliding scale when the resident's FSBS was less than 200. -The Novolog sliding scale did not have any parameters that would have required 8 units of insulin to be administered. -The routine 8 units of Novolog was also documented as administered on those 15 occasions, which appeared the resident received 16 units of Novolog on those occasions. -No sliding scale would be required on those occasions. -Staff double documented the routine Novolog insulin administration under the routine Novolog entry and under the sliding scale Novolog entry on the MAR. -The residents FSBS range for February 2018 was 58-456. Review of Resident #1's March 2018 e-MAR revealed: -There was an entry for Novolog inject 8 units with meal, hold if FSBS is less than 110 or the resident does not eat the meal. -The routine Novolog was scheduled to be administered at 8:00 a.m., 12:00 p.m. and 5:00 p.m. -There was an entry for Novolog sliding scale with	D 367		

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D 367	Continued From page 35 meals according to the following scale: less than 220 = o units, 201-250 = 1 unit, 251-300 = 2 units, 301-350 = 3 units, 401- 450 = 5 units. -The Novolog sliding scale was scheduled to be administered at 8:00 a.m., 12:00 p.m. and 5:00 p.m. -The routine Novolog was documented as administered at all times except held on three occasions per doctor order. -Eight units of Novolog were documented as administered on 9 occasions under the entry for the Novolog sliding scale insulin. -The Novolog sliding scale did not have any parameters that would have required 8 units of insulin to be administered. -The routine 8 units of Novolog was also documented as administered on those 9 occasions, which appeared the resident received 16 units of Novolog on those occasions. -No sliding scale would be required on those occasions. -Staff double documented the routine Novolog insulin administration under the routine Novolog entry and under the sliding scale Novolog entry on the MAR. -The residents FSBS for March 1-13, 2018 was 52-383. Interview with a medication aide (MA) on 03/15/18 at 10:45 a.m. revealed: -When he initialed the e-MAR it meant he had administered the medication. -He was not aware he was initialing the routine Novolog in the wrong section until the Care Coordinator spoke to him on 03/14/18. -He did not administer 16 units of Novolog on those occasions. -He had administered 8 units of Novolog insulin on those occasions.	D 367		

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D 367	Continued From page 36 Interview with a second MA on 3/14/18 at 5:20 p.m. revealed: -She had not administered 8 units of Novolog sliding scale insulin. -She initialed the wrong spot on the MAR she thought she was documenting the scheduled dose of insulin. Interview with the Care Coordinator on 03/14/18 at 1:40 p.m. revealed: -She had not checked the e-MARs for accuracy of documentation. -The scheduled dose of Novolog should not be documented with the sliding scale Novolog. Attempted interview on 03/14/18 at 4:10 p.m. and on 03/15/18 at 11:00 a.m. with Resident #1's primary care provider was unsuccessful.	D 367		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration. The findings are:	{D912}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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
{D912}	Continued From page 37 Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 4 residents (#1, #4) observed during the medication passes including errors with timing of insulin administration (#1, #4) and an antibiotic ear drop (#1); and for 3 of 5 residents (#1, #2, #4) sampled including errors with sliding scale insulin (#1, #2) and failure to hold scheduled insulin for low blood sugar parameters and when resident did not eat meals (#1, #4). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation)].	{D912}		