STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060116	A. BUILDING: _____ B. WING _____	09/12/2019

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SUMMIT PLACE OF SOUTHPARK	2101 RUNNYMEDE LANE CHARLOTTE, NC 28209

(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 the Mecklenburg County Department of Social Services conducted an annual survey on 09/11/19-09/12/19.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, interview, and record reviews, the facility failed to theraputic diets were served as ordered for 1 of 3 sampled residents (Resident #3) with an order for nectar thickened liquids. The findings are: Review of Resident #3's current FL-2 dated 09/05/19 revealed diagnoses included congestive heart failure exacerbation, shortness of breath, bradycardia, and dysphagia. Review of a physician's order dated 09/11/19 revealed Resident #3 was to receive a mechanical soft diet with nectar thickened liquids. Review of the therapeutic diet diet list posted in a dining room cabinet on 09/11/19 revealed Resident #3 was to be served nectar thickened liquids. Observation of the kitchen area on 09/11/19 at	D 310		

Reviewed and accepted- 11/07/19 SYR

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D 310	Continued From page 1 9:53am revealed there were several containers of nectar consistency pre-thickened water, tea, and milk available for administration. Observation of the Special Care Unit (SCU) refrigerator on 09/11/19 at 11:55am revealed there was a container of pre-thickened nectar consistency lemon-flavored water and tea available for administration. Observation of the lunch meal service on 09/11/19 from 11:55am to 1:15pm revealed: -Resident #3 was served thin water instead of nectar consistency thickened water. -Resident #3 proceeded to drink the thin water, the surveyor requested the server check the diet order. -A personal care aide (PCA) informed the server Resident #3 was to receive nectar thickened liquids. -The thin water was removed from Resident #3's place setting and replaced in nectar consistency pre-thickened water. Review of the diet list posted in the kitchen on 09/11/19 at 9:30am revealed Resident #3 was to be served nectar consistency thickened liquids. Interview with the activities assistant/medication aide (MA) on 09/11/19 at 3:47pm revealed: -She served thin water to Resident #3 by mistake. -She had not referenced the diet list prior to serving Resident #3 her drinks. -She did not realize Resident #3's diet order had changed to nectar thickened liquids on 09/11/19. -Resident #3's diet order was current as 09/11/19 for nectar consistency thickened liquids. -"I should have referred to the diet list before serving lunch".	D 310	Food Service Director(FSD), and BTR Director provided education for staff in SCU regardingTherapeutic Diets and the importance of residents receiving correct diets. on 9/20/19 Bridge To Rediscovery ,(BTR) Director educated staff on 9/20/19, regarding daily /shift review of all resident diets, and communicate during each shift Stand up for any changes in resident diets daily. Beginning 9/20/19, Food Service Director, Executive Director, and/or Designee, will train all new staff during Onboarding regarding Therapeutic Diets, and the importance of resident receiving correct diets. All documentation will be kept in the BOM office in staff personnel file. Regional Director of Dining reviewed with the Food Service Director and Executive Director the Therapeutic diets to include : Therapeutic spread sheets, Diet Roster, on 10/17/19. Recipe books, and weekly At Risk Meetings, to ensure compliance with policy and procedures. Documentation will be kept on POC binder in the ED office for review for the County/State. FSD provided education for staff in the Memory Care Neighborhood Regarding Therapeutic Diets, and the importance on residents receiving correct diets. Food Service Director, Executive Director, and/ or Designee will educate staff in our monthly All Staff meeting on 10/23/2019, regarding the Therapeutic diets and the importance to know and follow the resident diets. 10/23/19 FSD, ED, and/or Designee will complete ongoing trainings with staff regarding Therapeutic diets and reviewing Diet books/board with daily/shift communication in team member standup.	

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D 310	Continued From page 2 Observation of the dinner meal service on 09/11/19 from 5:00pm to 5:30pm revealed: -Resident #3 was served a thin liquid soup. -Resident #3 began eating the thin liquid soup. -The thin liquid soup was removed from Resident #3's place setting. Interview with a PCA on 09/11/19 at 5:03pm revealed: -Resident #3 was not supposed to have the soup, he thought another resident was going to sit where Resident #3 was sitting. -He did not have a thickened soup to serve Resident #3. -The PCA was not able to call the kitchen because the phone in the SCU was not working. -He would need to call the kitchen to prepare nectar consistency thickened soup for Resident #3. Interview with the Dietary Manager (DM) on 09/11/19 at 5:09pm revealed: -Nectar consistency thickened soup for residents with orders for thickened liquids was usually thickened if the resident requested an appetizer. -If a resident wanted soup it would be thickened by the DM in the main kitchen. -He did not know Resident #3 wanted soup for dinner. -He would expect staff to let him know; he did not know the phone in the SCU was not working. -He should have sent a nectar consistency thickened soup to the SCU for Resident #3 just in case she wanted soup. Interview with the Special Care Coordinator (SCC) on 09/11/19 at 3:00pm revealed: -Diet orders were updated on the diet list as they were received from the physician. -Resident #3's diet was updated on the list and	D 310	Ongoing, FSD, ED, and/or Designee will complete random meal audits three times per week for twelve weeks to ensure all diets are served as ordered. Documentation will be kept in the ED office in POC binder for review by the County/State. Starting 10/7/19. Bridge to Rediscovery (BTR) Director provided education to staff on phone usage for internal calls, external calls, transfers, and hold. on 9/11/19.	

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D 310	Continued From page 3 placed in the binder in the SCU. -She expected staff to refer to the diet list in the dining area prior to serving residents' meals. -There was also a book in an office in the SCU that staff could reference for updated physician orders. Interview with the Hospice Nurse for Resident #3 on 09/12/19 at 9:34am revealed: -Resident #3 was ordered nectar thickened liquids as a precaution. -Resident #3 had a pending speech therapy (ST) consultation due to recent coughing during meals. -The physician ordered nectar thickened liquids as a precaution while waiting on the recommendations from ST. -Resident #3 had not experienced aspiration to her knowledge. Interview with Administrator on 09/12/19 at 8:20am revealed: -Staff should be communicating order changes with each other and referring to the communication book each shift. -Staff were also responsible for referring to the diet list prior to serving residents. -The kitchen staff should also be preparing food for the residents as ordered prior to sending it to the SCU to prevent residents from being served the incorrect diet. -Drinks and soups should be served to the ordered consistency to prevent aspiration. Attempted telephone interview with Resident #3's primary care provider (PCP) on 09/12/19 at 8:43am was unsuccessful. Based on observation, interview, and record review it was determined Resident #3 was not interviewable.	D 310		

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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 ensure medication orders were clarified with the prescribing practitioner for 2 of 5 sampled residents (Resident #2 and #6) related to sliding scale insulin parameters (Resident #6) and holding blood pressure medication due to parameters (Resident #2). The findings are: 1. Review of Resident #6's current FL2 dated 03/02/19 revealed: -Diagnoses included diabetes mellitus. -There was an order to check fingerstick blood	D 344	MAR to cart audits were conducted and compared to Medical Director orders for accuracy on 9/11/19.	

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D 344	Continued From page 5 sugars (FSBS) four times a day. -There was an order for Humalog KwikPen (used to control blood sugar levels) 100units/ml with sliding scale: 300-350=4 units; 351-400=6 units; 401-450=8 units, notify primary care provider (PCP) if blood sugar is greater than 451. Review of Resident #6's subsequent physician's order dated 07/08/19 revealed: -There was an order for FSBS to be taken 4 times a day. -There was an order for Humalog KwikPen 100units/ml sliding scale "as needed". Review of Resident #6's record revealed a physician's order on 07/08/19 for Humalog insulin 100u/ml, administer 5 units three times a day with meals. Observation of Resident #6's medications on hand on 09/11/19 at 11:51am revealed: -There was a plastic bag containing the Humalog insulin KwikPen, with an open date of 08/30/19. -The bag had a pharmacy generated label with Resident #6's name and Humalog KwikPen 100units/ml. -The instructions on the pharmacy label read: "inject use per sliding scale: 300-350=4 units; 351-400=6 units; 401-450=8 units; if greater than 451 notify the PCP. Review of Resident #6's August 2019 Medication Administration Record (MAR) revealed: -There was an entry for FSBS checks, four times daily, scheduled at 7:30am, 11:30am and 4:30pm. -There was an entry for Humalog KwikPen 100units/ml, to control elevated blood sugar levels, with sliding scale parameters of: 300-350=4 units; 351-400=6 units; 401-450=8	D 344 10/28/19	Education was initiated on 9/24/19 for Medical Technicians by nursing, this training was completed on 10/3/19, Training included: Diabetes Insulin & Blood Glucose Management and Infection Control Omnicare Pharmacy performed Medication Administration audits on 9/30/19 and 10/1/19 with Medication Technicians Observation competency. Random Medication administration observation audits will begin the week of October 28th, Completed by nursing administration, and/or designee three times per week for one week, and bi-weekly for 12 weeks to ensure compliance. Documentation will be kept in the ED office in the plan of correction binder for County/State review.	

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D 344	Continued From page 6 units, notify the PCP if blood sugar was greater than 451. -There was documentation on 08/05/19 at 4:30pm Resident #6's FSBS was 329. -Based on the sliding scale parameters, Resident #6 should have received 4 units of insulin. -There was no documentation Resident #6 received 4 units of Humalog insulin. -There was documentation on 08/11/19 at 4:30pm Resident #6's FSBS was 304. -Based on the sliding scale parameters, Resident #6 should have received 4 units of insulin. -There was no documentation Resident #6 received 4 units of Humalog insulin. -There was documentation on 08/15/19 at 4:30pm Resident #6's FSBS was 303. -Based on the sliding scale parameters, Resident #6 should have received 4 units of insulin. -There was no documentation Resident #6 received 4 units of Humalog insulin. -There was documentation on 08/19/19 at 4:30pm Resident #6's FSBS was 366. -Based on the sliding scale parameters, Resident #6 should have received 6 units of insulin. -There was no documentation Resident #6 received 6 units of Humalog insulin. Review of Resident #6's September 2019 MAR revealed: -There was an entry for FSBS checks, four times daily, scheduled at 7:30am, 11:30am and 4:30pm. -There was an entry for Humalog KwikPen 100u/ml with sliding scale: 300-350=4 units; 351-400=6 units; 401-450=8 units, notify the PCP if blood sugar was greater than 451. -There was documentation on 09/04/19 at 4:30pm Resident #6's FSBS was 308. -Based on the sliding scale parameters, Resident #6 should have received 4 units of insulin.	D 344		

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D 344	Continued From page 7 -There was no documentation Resident #6 received 4 units of Humalog insulin. Interview with the medication aide (MA) on 09/11/19 at 11:55am revealed: -Resident #6 did not have a sliding scale order. -Resident #6 only received a scheduled dose of 5 units of Humalog insulin before meals. -She did not know Resident #6 had an order on the MAR for Humalog KwikPen 100units/ml for sliding scale with parameters. -She only administered the scheduled Humalog insulin to Resident #6. -She did not know why the pharmacy generated label for Resident #6's KwikPen had sliding scale parameters. -She had never sought clarification of Resident #6's sliding scale orders. Interview with the Special Care Coordinator (SCC) on 09/11/19 at 2:54pm revealed: -She did not know Resident #6 had an order for Humalog KwikPen 100units/ml with sliding scale parameters -She and the MAs performed weekly cart audits. -The process for cart audits was to compare the medication on the cart to the order on the MARs, check for expired medications and medications that needed to be refilled. -She did not remember seeing the Humalog sliding scale order on the MARs. -She knew the pharmacy generated label on the Humalog KwikPen did not reflect the scheduled order, but the previous Director of Nursing had assured her she could administer the scheduled insulin from the KwikPen. -She would clarify the sliding scale order with the physician when she arrived at the facility today. Interview with the Administrator on 09/12/19 at	D 344		

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D 344	Continued From page 8 1:47pm revealed: -She did not know insulin orders were not being followed by the MAs. -The MAs had just completed a diabetic training class and a refresher course on medication administration. -She expected staff to communicate with the physician when there were questions about any order. -She expected the MAs to communicate with the nursing staff and the nursing staff to follow up with a physician about any questions they had with a medication order. -If a medication label did not match an order, the MAs should clarify the order with the nursing staff and physician. Interview with the interim facility nurse on 09/12/19 at 3:00pm revealed: -If a physician's order was incomplete, the MA could reach out to the physician by either calling their office or sending a fax for clarification. -The nursing staff could also seek clarification if the physician's instructions were unclear or it was missing information. -The MAs were responsible for the medications on their carts. -The MAs should have requested clarification of Resident #6's sliding scale insulin order. -Cart audits were completed weekly. She did not know why Resident #6's Humalog sliding scale order was not identified during a cart audit. Interview with a Licensed Practical Nurse (LPN) on 09/12/19 at 3:25pm revealed: -The pharmacy sent computerized MARs to the facility on the third week of the present month for the following month. -He reviewed the orders on the MARs from the previous month and verified the accuracy of the	D 344		

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D 344	Continued From page 9 present month's orders when they arrived from the pharmacy. -Either the MA or nursing staff should seek clarification of a physician order that did not have complete information or instructions. Telephone interview with a representative from the contracted pharmacy on 09/12/19 at 4:45pm revealed: -Resident #6's Humalog KwikPen 100units/ml with sliding scale: 300-350=4 units; 351-400=6 units; 401-450=8 units, notify the PCP if blood sugar is greater than 451 was an active order. -The pharmacy filled the insulin medications at the request of the facility staff. -The facility staff removed the label of the medication being requested and attached the label to a refill request form. -The form was faxed to the pharmacy staff. -Resident #6's KwikPen 100units/ml had been prescribed for the scheduled 5 unit dose before meals and the sliding scale parameters. -If the label for the KwikPen with the sliding scale orders was the only refill request, it would be the only insulin pen filled. Telephone interview with Resident #6's primary care physician (PCP) on 09/12/19 at 5:30pm revealed: -She did not know Resident #6's sliding scale orders were not being followed. -She did not know the sliding scale orders were incomplete. -Prior to this time she had not reconciled Resident 6's orders before signing the MARs. -She thought if she had not made any order changes, the MARs would be correct from the previous month. -She realized the MARs may have inconsistencies or errors and she would have to	D 344		

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D 344	Continued From page 10 review each order before signing the MARs going forward. -She was concerned the MAs were not administering the medications as prescribed. -She expected the facility staff to seek clarification from her if any written orders were unclear or missing information. -She had not received any requests from the facility staff to clarify Resident #6's insulin orders. -If Resident #6 did not receive her sliding scale insulin she could become hyperglycemic. 2. Review of Resident #2's FL-2 dated 04/22/19 revealed: -Diagnoses included hypertension, Parkinson's disease, hyperlipidemia and incontinence. -There was an order for Amlodipine (used to treat high blood pressure) 5mg, 1 tab every day. -There was an order for Lisinopril (used to treat high blood pressure) 5mg, 1 tab every day. -There was an order for metoprolol tartrate (used to treat high blood pressure) 25mg a ½ tablet at bedtime. Review of Resident #2's subsequent physician's orders dated 07/10/19 revealed: -There was a physician's order with instructions to hold BP (blood pressure) medication if systolic blood pressure (SBP) was at or below 110 and/or diastolic blood pressure (DBP) at or below 70 and monitor daily BPs. -The physician's order did not indicate which blood pressure medication was to be held according to the parameters. Review of Resident #2's record revealed there was no documentation that the facility contacted the prescribing physician seeking clarification of the medication order dated 07/10/19.	D 344		

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D 344	Continued From page 11 Review of Resident #2's July 2019 Medication Administration Record (MAR) revealed: -The MAR was updated on 07/10/19 with hand written transcribed instructions entry to monitor blood pressure daily and hold BP medication if SBP was at or below 110 and DBP was at or below 70. -The hand-written entry had two sets of initials with the first one belonging to a MA and the second one belonging to a Licensed Practical Nurse (LPN). -The documented BP reading on 07/30/19 at 10:00am was 135/70. -Resident #2 had three medications listed on the July 2019 MAR to treat high blood pressure: Amlodipine Besylate, Lisinopril and Metoprolol Tartrate. -All three medications were documented as being administered on one occasion (07/30/19) when the DBP was at or below 70. Review of Resident #2's August 2019 MAR revealed: -There was an entry for the blood pressure to be checked every day, hold blood pressure medications if SBP at or below 110, and/or DBP at or below 70. -The BP readings were taken at 10:00am with documented readings on 08/10/19 of 128/70, 08/14/19 of 146/68, 08/15/19, of 138/65, 08/25/19 of 132/66, 08/27/19 of 181/67 and 08/30/19 of 157/70. -Resident #2 had three medications listed on his August 2019 MAR to treat high blood pressure: Amlodipine Besylate, Lisinopril and Metoprolol Tartrate. -All three medications were documented as being administered on 08/10/19, 08/14/19, 08/15/19, 08/25/19, 08/27/19 and 08/30/19) when the DBP	D 344		

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D 344	Continued From page 12 was at or below 70. Review of Resident #2's September 2019 MAR revealed: -There was an entry for the blood pressure to be checked every day, hold blood pressure medications if SBP at or below 110, and/or DBP at or below 70. -The BP reading was taken at 10:00am on 09/08/19 and documented as 123/64. -Resident # 2 had three medications listed on his September 2019 MAR to treat high blood pressure: Amlodipine Besylate, Lisinopril, and Metoprolol Tartrate. -All three medications were documented as being administered on 09/08/19 when the DBP was at or below 70. Interview with a medication aide (MA) on 09/12/19 at 9:00am revealed: -She was aware of the order to hold the BP medication but was uncertain about which BP medication to hold since Resident #2 had three medications that treated his high blood pressure. -She felt the physician order needed clarification. -She did not notify the supervisor, Licensed Practical Nurse (LPN) or the Director of Nursing (DON). -She did not know why she had not communicated this to Resident #2's physician nor anyone on the nursing staff. Interview with a second MA on 09/12/19 at 4:30pm revealed: -She knew about the physician's order to hold BP medication for Resident #2. -She noticed the order did not specify which BP medication to hold so she decided she would hold all three medications. -She recognized the order needed clarification,	D 344		

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D 344	Continued From page 13 but she had not taken any action to get the clarification since she decided to hold all three medications. -She knew she could contact the physician for clarification of orders. Interview with Resident #2's physician on 09/12/19 at 5:24pm revealed: -She was unable to speak on any potential outcome to Resident #2 receiving his BP medications outside of the parameters. -She expected the facility staff to seek clarification from her if any written orders were unclear or missing information. Interview with the interim facility nurse on 09/12/19 at 3:00pm revealed: -The process the facility used for receiving a physician order was the MA received the order, completed a tracking form, made a copy of the order, faxed the copy to the pharmacy and filed the original order in the resident's record. -The MA placed the tracking form in the "new order mailbox" for the nursing staff to review. -The MA wrote the new physician's order on the current MAR and it was then reviewed for accuracy and initialed by staff from the nursing department upon completion. -If a physician's order was incomplete, the MA could reach out to the physician by either calling their office or sending a fax for clarification. -The nursing staff could also seek clarification if the physician's instructions were unclear or it was missing information. Interview with an LPN on 09/12/19 at 3:15pm revealed: -Upon receiving a new physician's order, the MA on duty updated the MAR, completed a tracking form, made a copy of the order and faxed it to the	D 344		

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D 344	Continued From page 14 pharmacy and then filed the original copy in the resident's record. -The MA placed the tracking form in the nursing staff mailbox. Upon receiving the tracking form, a nursing staff reviewed the physician's order and looked at the MAR to ensure it was written correctly and then initialed off that they had reviewed it. -Either the MA or nursing staff could seek clarification of a physician's order that did not have complete information or instructions. -After reviewing the physician's order for Resident #2 dated 07/10/19, he felt the receiving MA and/or nursing staff should have asked the physician to clarify which medication(s) should have been held. Interview with the Administrator on 09/12/19 at 1:20pm revealed: -The facility had a two-step process for receiving new physician orders. First the MA received the order and completed a tracking form which alerted the nursing staff that a new order was received. Second, a nursing staff reviewed and approved the order that was written on the current MAR. -She felt clarification was needed on the physician's order dated 07/10/19 written for Resident #2 and "it should have been caught". -She expected her staff to follow the established process for new orders and communicate with the physician when there were questions about any order. -She expected the MAs to communicate with the nursing staff and the nursing staff to follow up with a physician about any questions they had with a medication order.	D 344		

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D 352	Continued From page 15	D 352		
D 352	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed; (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date; (8) auxiliary statements as required of the medication; (9) the name, address, telephone number of the dispensing pharmacy; and (10) the name or initials of the dispensing pharmacist. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure insulin pens were properly labeled for 3 of 6 sampled residents (Residents #1, #6 and #7). The findings are: 1. Review of Resident #6's current FL2 dated 03/02/19 revealed: -Diagnoses included diabetes mellitus. -There was an order for Humalog KwikPen 100units/1ml, (used for the control of blood sugar	D 352		

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D 352	Continued From page 16 levels), inject per sliding scale: 300-350=4 units; 351-400=6 units; 401-450=8 units, notify primary care provider (PCP) if the blood sugar (BS) is greater than 451. -There was an order to check the FSBS 4 times daily. Review of Resident #6's subsequent physician's order dated 07/08/19 revealed: -There was an order for Humalog KwikPen 100units/ml, 5 units to be administered daily with meals. -Hold the insulin if the blood sugar is less than 100. -Continue Humalog sliding scale as needed. Observation of Resident #6's Humalog KwikPen available for administration on 09/11/19 at 11:50am revealed: -There was a plastic bag containing the Humalog insulin Kwik Pen. -The plastic bag had a handwritten opened date of 08/20/19 on the label. -The bag had a pharmacy generated label with Resident #6's name and 'Humalog KwikPen 100units/ml'. -The instructions on the pharmacy label read: "inject use per sliding scale: 300-350=4 units; 351-400=6 units; 401-450=8 units; if greater than 451 notify the primary care provider (PCP). -The label on the Humalog insulin did not include instructions for the scheduled dose of 5 units three times a day before meals. -There was no label or sticker indicating there were additional instructions. -There was no other Humalog KwikPen available for administration. Interview with the medication aide (MA) on the Special Care Unit (SCU) medication cart on	D 352	Omnicare Pharmacy was consulted on 10/15/19 regarding label changes with new Medication Orders. Nurse was advised to use change in direction label stickers to indicate a new order of medication prescribed by Physician. Medication Technicians were educated by Nurse to use direction label stickers to indicate a new order of medication prescribed by Physician on 10/23/19. Omnicare Pharmacy provided a DO NOT CRUSH list of medications. Copies of this list are available for reference in the MAR Books. Medication Technicians were educated on 10/23/19 by nursing. Education was initiated on 9/24/19 for Medical Technicians by nursing, this training was completed on 10/3/19, Training included: Diabetes Insulin & Blood Glucose Management and Infection Control. 10/28/19 Random Medication administration observation audits will begin the week of October 28th, Completed by nursing administration, and/or designee three times per week for one Week, and bi-weekly for 12 weeks to ensure compliance. Documentation will be kept in the ED office in the plan of correction binder for County/State review.	

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D 352	Continued From page 17 09/11/19 at 11:55am revealed: -Resident #6 did not have a sliding scale order for Humalog insulin. -Resident #6 only received a scheduled dose of 5 units of Humalog insulin before meals. -The MA had not used any other KwikPen to administer the scheduled Humalog insulin to Resident #6. -She did not know why the pharmacy generated label for the Humalog KwikPen had directions for sliding scale insulin administration. Interview with the second shift MA on the SCU medication cart on 09/11/19 at 3:45pm revealed: -She had been trained as a MA recently by the MA supervisor. -She checked the label on the medications with thé orders on the MARs before she administered medications. -She knew the label on Resident #6's Humalog KwikPen was for sliding scale parameters. -The MA supervisor she trained under stated it was the only insulin pen for Resident #6 so it could be used for the scheduled order. -She did not know Resident #6 had a sliding scale order on the MARs. Telephone interview with a representative from the contracted pharmacy on 09/12/19 at 4:45pm revealed: -Resident #6 had an order for a Humalog KwikPen 100units/ml, 5 units to be administered daily with meals. -Resident #6 had an order for a Humalog KwikPen 100units/ml, 5 units to be administered as needed per sliding scale parameters. -The pharmacy filled the insulin medications at the request of the facility staff. -The facility staff removed the label of the medication being requested and attached the	D 352		

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D 352	Continued From page 18 label to a refill request form. -The refill request form was faxed to the pharmacy staff. -If the label for the KwikPen with the sliding scale orders was the only refill request, it would be the only insulin pen filled. Refer to interview with the interim Director of Nursing (DON) on 09/12/19 at 2:46pm. Refer to interview with the Administrator on 09/12/19 at 1:47pm. 2. Review of Resident #7's current FL2 dated 04/09/19 revealed: -Diagnoses included diabetes mellitus. -There was an order for Novolog insulin 100units/ml used for the control of elevated blood sugar levels, inject 4 units with breakfast. -There was an order for Novolog insulin 100units/ml inject 8 units every day with lunch. -There was an order for FSBS 3 times daily before meals and administer Novolog insulin 100units/ml as needed per sliding scale: 150-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units, 351-400=6 units; over 400=7 units. Observation of Resident #7's Novolog insulin available for administration on 09/12/19 at 7:40am revealed: -There was a medicine bottle containing a vial of Novolog insulin 100units/ml, with an opened date of 08/18/19. -The medicine bottle had a pharmacy generated label with Resident #7's name and 'Novolog 100units/ml'. -The instructions on the pharmacy label read: "inject 4 units before breakfast and inject 8 units before lunch".	D 352		

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D 352	Continued From page 19 -The Novolog insulin label did not include instructions for the sliding scale insulin. -There was no label or sticker indicating there were additional instructions. -There was no other Novolog insulin available for administration for Resident #7. Interview with the first shift medication aide on 09/12/19 at 3:20pm revealed: -When administering medications, she referred to the order entry on the MAR and the information on the medication. -She confirmed the resident's name, the name of the medication and the correct dosage on the medication label. -She knew the label for Resident #7's insulin vial did not have the instructions for the sliding scale parameters. -She used the insulin vial with the directions for the scheduled insulin because it was the same insulin (Novolog 100units/ml). -She probably should have informed the nursing staff the label for the sliding scale was not on the insulin vial. -That was "probably an error on my part". Interview with a second MA on 09/12/19 at 3:45pm revealed: -The MAs and the nursing staff were responsible for completing cart audits. -The medications on the cart were compared to the orders entered on the MARs. -The medication labels were checked to ensure the directions matched the orders. -There were direction sticker change labels that could be added to a medication if needed and were kept on the cart. -She did not know why labels on medications were incorrect if MAs were performing the cart audits correctly.	D 352		

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D 352	Continued From page 20 -It was the responsibility of all the MAs to read labels before administering medications and informing the nursing staff if the labels were incorrect. Refer to interview with the interim Director of Nursing (DON) on 9/12/19 at 2:46pm. Refer to interview with Administrator on 09/12/19 at 1:47pm. 3. Review of Resident #1's current FL2 dated 08/26/19 revealed: -Diagnoses included diabetes mellitus, hypertension, and hyperlipidemia. a. Review of Resident #1's FL2 dated 08/26/19 revealed: -There was an order for Humalog (used to control blood sugar levels) inject 4 units subcutaneously before supper and hold if blood sugar is less than 100. -There was an order for Humalog sliding scale insulin (SSI) fingerstick blood sugars (FSBS) before meals and at bedtime: 150-200= 2 units, 201-250= 4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, greater than 400 call the physician. Observation of Resident #1's Humalog insulin available on the medication cart on 09/12/19 at 11:15am revealed: -There was one medication bottle that included a vial of Humalog insulin. -The Humalog insulin had a pharmacy generated label with Resident #1's name. -The instructions on the Humalog insulin read "inject 4 units subcutaneously before meals and hold if the blood sugar less than 100 and FSBS before meals and at bedtime SSI:".	D 352		

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D 352	Continued From page 21 -The Humalog insulin did not include instructions for the SSI as ordered by the physician. -There was no label or sticker indicating there were additional instructions. -There was no other medication bottle with Humalog insulin available for administration. Interview with the medication aide (MA) on 09/12/19 at 1240pm revealed: -She realized the instructions for the Humalog sliding scale was not listed on the medication label. -She would refer to the medication administration record (MAR) for the sliding scale insulin. -If an order changed or the instructions were different than the label a yellow change sticker was placed on the bottle. -MAs were responsible for placing the change sticker on the bottle. -She did not know why a change sticker was not placed on the bottle to indicate there were further instructions. Refer to interview with the interim DON on 09/12/19 at 2:46pm. Refer to interview with the Administrator on 09/12/19 at 1:47pm. b. Review of Resident #1's FL2 dated 08/26/19 revealed: -There was an order for Lantus insulin inject 17 units subcutaneously every morning. -There was an order for Lantus insulin inject 10 units subcutaneously every night. Observation of Resident #1's Lantus (used to control blood sugar levels) insulin available on the medication cart on 09/12/19 at 11:15am revealed: -There was one medication bottle that included a	D 352		

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D 352	Continued From page 22 vial of Lantus insulin. -The Lantus insulin had a pharmacy generated label with Resident #1's name. -The instructions on the Lantus insulin read "inject 17 units subcutaneously twice daily". -There was no label or sticker indicating there were additional or new instructions. -There was no other medication bottle with Lantus insulin available for administration. Interview with the medication aide (MA) on 09/12/19 at 1240pm revealed: -She realized the instructions for the Lantus insulin were incorrect on the medication label. -She would refer to the medication administration record (MAR) for the correct Lantus insulin. -If an order changed or the instructions were different than the label a yellow change sticker was placed on the bottle. -MAs were responsible for placing the change sticker on the bottle. -She did not know why a change sticker was not placed on the bottle to indicate there were further instructions. Refer to interview with the Administrator on 09/12/19 at 1:47pm. Refer to interview with the interim DON on 09/12/19 at 2:46pm. _____ Interview with the Administrator on 09/12/19 at 1:47pm revealed: -She did not know the MAs were not ensuring medication labels and orders matched. -The MAs had just completed a diabetic training class and a refresher course on medication administration. -If a medication label did not match an order, the	D 352		

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D 352	Continued From page 23 MAs should clarify the order with the nursing staff and physician. -She expected the MAs to communicate with the nursing staff to follow up with a physician about any questions they had with a medication order. Interview with the interim Director of Nursing (DON) on 09/12/19 at 2:46pm revealed: -Labels on the medication bottle should match the physician's orders. -The MAs should check the medications received from the pharmacy and the labels should match the current order and the MAR. -The MAs were supposed to let her know if the medication label did not match the medication order. -She would contact the pharmacy to get a correct medication label. -She had not contacted the pharmacy regarding replacing the labels for any of the residents at the facility. -She had not noticed incorrect medication labels for any of the residents in the facility.	D 352		
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.	D 358	Effectively immediately, Medication Technicians will be in-serviced on Medication Administration on all shifts by an RN. Supervisor in Charge will begin Cart to MAR audit immediately as of 9/12/19. Over sight will be provided by DRC, ED, and or Designee.	

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D 358	Continued From page 24 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents (Resident #7) related to a medication for low potassium levels during the 7:40am medication pass on 09/12/19 and 1 of 5 sampled residents for a record review (Resident #6) related to a sliding scale insulin. The findings are: The medication error rate was 10 % (percent) as evidenced by the observation of 3 errors out of 29 opportunities, during the 7:30am medication pass on 09/11/19. 1. Review of Resident #7's current FL2 dated 04/09/19 revealed: -Diagnoses included mitral valve regurgitation, Chrohn's disease and hypothyroidism. -There was an order for potassium chloride extended release (ER) 20 mEq, used to treat low low blood potassium, one tablet twice a day. Observation of the 2nd floor medication pass on 09/12/19 at 7:40am revealed: -The medication aide (MA) dispensed 8 tablets in a medication cup for Resident #7. -The MA applied gloves and brought the	D 358	Going forward, Medication Administration records will be reviewed and monitored on a monthly basis by DRC, ED, and/or Designee. Any new orders will be reviewed by DRC, ED, and/or Designee. Medication Technicians have received education for Medication Administration by Nursing was initiated on September 30, 2019, and completed by October 3, 2019. Documetnation will be kept in ED office on Plan of Correction binder for County/State review. 10/28/19 Random Medication administration observation audits will begin the week of October 28th, Completed by nursing administration, and/or designee three times per week for one week, and bi-weekly for 12 weeks to ensure compliance. Documentation will be kept in the ED office in the plan of correction binders for State/County review.	

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D 358	Continued From page 25 medications with a 6 ounce cup of water to Resident #7. -Resident #7 requested the potassium chloride tablet to be split in half. -The MA split the potassium chloride ER tablet in half by hand and administered to Resident #7. Interview with a medication aide on 09/12/19 at 3:15pm revealed: -Resident #7 requested large medication tablets be split in half because she had difficulty swallowing them. -The MA split the potassium chloride tablet in half because she was concerned Resident #7 would choke. -She knew extended release tablets should not be split in half, but she did not want the resident to choke on the tablet. -Resident #7 had an order to administer her medications with applesauce, but she just "sucked the applesauce off the pills" and still requested the potassium chloride tablet to be halved. -The MA did not notify Resident #7's physician she was experiencing difficulty swallowing large tablets. Interview with the Administrator on 09/12/19 at 1:47pm revealed: -She did not know medication orders were not being followed by the MAs. -The MAs had just completed a refresher course on medication administration. -She expected her staff to follow the protocol for extended release medications. -Extended release medications were never to be split or crushed when administering to a resident. Interview with the interim facility Registered Nurse on 09/12/19 at 3:00pm revealed:	D 358	Type text here	

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D 358	Continued From page 26 -The MAs had been taught they were not to split or crush any medication labeled ER or XR. -Without a "crush" order for medication, staff did not split tablets. -If a resident could not swallow a medication, the physician should be informed and their directives followed. Telephone interview with a representative from the contracted pharmacy on 09/12/19 at 4:45pm revealed: -Extended release medications were formulated so the drug was released over time. -The advantage was sometimes less medication was needed and/or there were less side effects. -If an extended release medication was split, more medication was released into the system which had various outcomes depending on the medication. -When a medication was extended release it should not be split or crushed. Telephone interview with Resident #7's primary care physician (PCP) on 09/12/19 at 5:30pm revealed: -She was concerned the MAs were not administering medications as prescribed. -Extended release medications should not be split or altered in any way. -The medication was formulated to be released slowly over time. -Splitting an extended release medication would alter the drug release times. The resident may get too much or too little of the medication. 2. Review of Resident #6's current FL2 dated 03/02/19 revealed: -Resident #6's diagnoses included diabetes mellitus. -There was an order to check fingerstick blood	D 358		

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D 358	Continued From page 27 sugars (FSBS) four times a day. -There was an order for Humalog KwikPen (used to control blood sugar) 100units/ml with sliding scale: parameters of: 300-350=4 units; 351-400=6 units; 401-450=8 units, notify primary care provider (PCP) if blood sugar is greater than 451. Review of Resident #6's record revealed a physician's order on 07/08/19 for Humalog insulin 100u/ml, administer 5 units three times a day with meals. Review of Resident #6's August 2019 Medication Administration Record (MAR) revealed: -There was an entry for FSBS checks, four times daily, scheduled at 7:30am, 11:30am and 4:30pm. -There was an entry for Humalog KwikPen 100units/ml, to control elevated blood sugar levels, with sliding scale parameters of: 300-350=4 units; 351-400=6 units; 401-450=8 units, notify the PCP if blood sugar was greater than 451. -There was documentation on 08/05/19 at 4:30pm Resident #6's FSBS was 329. -Based on the sliding scale parameters, Resident #6 should have received 4 units of insulin. -There was no documentation Resident #6 received 4 units of Humalog insulin. -There was documentation on 08/11/19 at 4:30pm Resident #6's FSBS was 304. -Based on the sliding scale parameters, Resident #6 should have received 4 units of insulin. -There was no documentation Resident #6 received 4 units of Humalog insulin. -There was documentation on 08/15/19 at 4:30pm Resident #6's FSBS was 303. -Based on the sliding scale parameters, Resident #6 should have received 4 units of insulin.	D 358		

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D 358	Continued From page 28 -There was no documentation Resident #6 received 4 units of Humalog insulin. -There was documentation on 08/19/19 at 4:30pm Resident #6's FSBS was 366. -Based on the sliding scale parameters, Resident #6 should have received 6 units of insulin. -There was no documentation Resident #6 received 6 units of Humalog insulin. Review of Resident #6's September 2019 MAR revealed: -There was an entry for FSBS checks, four times daily, scheduled at 7:30am, 11:30am and 4:30pm. -There was an entry for Humalog KwikPen 100u/ml with sliding scale: 300-350=4 units; 351-400=6 units; 401-450=8 units, notify the PCP if blood sugar was greater than 451. -There was documentation on 09/04/19 at 4:30pm Resident #6's FSBS was 308. -Based on the sliding scale parameters, Resident #6 should have received 4 units of insulin. -There was no documentation Resident #6 received 4 units of Humalog insulin. Interview with the medication aide (MA) on 09/11/19 at 11:55am revealed: -She did not know Resident #6 had an entry on the MAR for Humalog KwikPen 100units/ml with sliding scale parameters. -She never administered a sliding scale dose of Humalog insulin to Resident #6. -She only administered the Humalog 5 units to be administered before meals three times a day. Interview with the Special Care Coordinator (SCC) on 09/11/19 at 2:54pm revealed: -She did not know Resident #6 had an order for Humalog KwikPen 100units/ml with sliding scale parameters.	D 358		

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D 358	Continued From page 29 -She and the MAs performed weekly cart audits. -The process for cart audits was to compare the medication on the cart to the order on the MARs, check for expired medications and medications that needed to be refilled. -She did not remember seeing the Humalog sliding scale order on the MARs. -She did not know Resident #6 missed several doses of the Humalog sliding scale insulin in August and September 2019. Interview with the Administrator on 09/12/19 at 1:47pm revealed: -She did not know insulin orders were not being followed by the MAs. -The MAs had just completed a diabetic training class and a refresher course on medication administration. -She expected staff to read the entire MAR so every resident received the prescribed medications as ordered by the physician. Interview with the interim facility Registered Nurse on 09/12/19 at 3:00pm revealed: -The MAs were responsible for the medications on their carts. -The MAs should be especially careful with the administration of insulin. -She did not know why the MAs did not see the Humalog sliding scale order for Resident #6. -Cart audits were completed weekly. -She did not know why Resident #6's Humalog sliding scale order was not identified during a cart audit. Telephone interview with a representative from the contracted pharmacy on 09/12/19 at 4:45pm revealed: -Resident #6's Humalog KwikPen 100u/ml with sliding scale: 300-350=4 units; 351-400=6 units;	D 358		

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D 358	Continued From page 30 401-450=8 units, notify the PCP if blood sugar is greater than 451 was an active order. -The pharmacy staff filled the insulin medications at the request of the facility staff. -The facility staff removed the label of the medication being requested and attached the label to a refill request form. -The refill request form was faxed to the pharmacy staff. -Resident #6's Humalog KwikPen 100units/ml had been prescribed for both the scheduled 5 unit dose before meals and the sliding scale parameters. -If the label for the Humalog KwikPen with the sliding scale orders was the only refill request sent to the pharmacy, it would be the only insulin pen filled and sent to the facility. Telephone interview with Resident #6's primary care physician (PCP) on 09/12/19 at 5:30pm revealed: -She did not know Resident #6's sliding scale orders were not being followed. -Prior to this time she had not reconciled Resident 6's orders before signing the MARs. -She thought if she had not made any order changes, the MARs would be correct from the previous month. -She realized the MARs may have inconsistencies or errors and she would have to review each order before signing the MARs going forward. -She was concerned the MAs were not administering orders as prescribed. -The PCP was concerned that if Resident #6 was not receiving the sliding scale insulin as needed, her blood sugar levels would not be well controlled and Resident #6 could develop ketoacidosis, a potentially life threatening complication of diabetes.	D 358		

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D 358	Continued From page 31 The failure of the facility to administer medications as ordered related to an extended release potassium tablet that was split which could alter the effectiveness of the medication (Resident #7) and a diabetic resident not receiving the insulin she was prescribed based on the sliding scale parameters which could cause hyperglycemia, an elevated blood sugar . This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on September 11, 2019 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2019.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered in accordance with infection control measures for 2 of 3 sampled medication	D 371	Medication Technicians have been in-serviced by Nursing on Infection Control procedures, Diabetes Insulin & Blood Glucose Management, and Medication Administration, that was initiated on September 30, 2019, and completed on October 3, 2019.	

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D 371	Continued From page 32 aides, Staff A and Staff C not using appropriate hand hygiene techniques, not wearing gloves, and not disposing of and sanitizing diabetic supplies after taking a fingerstick blood sugar (FSBS). The findings are: 1. Observation of the medication pass in the Special Care Unit (SCU) on 09/11/19 at 11:40am revealed: -Staff A in the SCU prepared to perform an 11:30am scheduled fingerstick blood sugar (FSBS) on a resident. -She gathered the resident's glucometer, lancet, test strips, alcohol towelettes and gloves and proceeded to the resident's room. -Staff A did not sanitize her hands before applying gloves and obtaining a blood sample from the resident's right index finger. -After obtaining the blood sugar reading, Staff A laid the blood stained test strip, still in the glucometer, along with the lancet, on the resident's bed covers. -She gathered the glucometer with the bloody test strip and the lancet and returned to the medication cart, where she disposed of the lancet and used test strip in the sharps container. -Staff A documented the blood sugar reading in the medication administration record (MAR). -She did not use a hand sanitizer or wash her hands after the administration of the resident's FSBS and the removal of her gloves. -Staff A did not sanitize the glucometer before placing it back in the case and storing it in the medication cart. -She proceeded to the medication room to speak with her supervisor. Observation of the medication cart on 09/11/19 at	D 371	Individual plastic containers have been implemented on 10/14/19, to maintain infection control when performing finger sticks and administering insulin medication Going forward, plastic containers will be provided by clinical Nursing, ED, and or Designee for all new residents that are insulin dependent diabetics to ensure infection control is maintained. 10/28/19 Random Medication administration observation audits will begin the week of October 28th, Completed by nursing administration/designee three times per week for one Week, and bi-weekly for 12 weeks to ensure compliance. Documentation will be kept in the ED office in the plan of correction binders for County/State review. Type text here	

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D 371	Continued From page 33 11:50am revealed there was a bottle of hand sanitizer available on the medication cart. Interview with the Staff A on 09/11/19 at 11:55am revealed: -She did not know the blood stained test strip and lancet left on a surface after usage violated infection control protocols. -She did not think the test strip was touching the resident's bed covers since it was still in the glucometer. -Staff A did not realize she did not sanitize her hands before and after she returned to the medication cart from performing a resident's FSBS. -She usually sanitized her hands after administering medications, FSBS readings and insulin injections. -Staff A had attended the infection control training and the diabetic/insulin training at the facility "sometime in the past few months." Interview with the Special Care Coordinator on 09/11/19 at 12:20pm revealed: -All the MAs were trained annually in the North Carolina (NC) Infection Control guidelines and Diabetic training by the Registered Nurse (RN) at the facility, and was used as their infection control policy. -The MAs were trained to dispose of the lancet and used test strip "at site"-(when the MA finished with each procedure). -The MAs should wash their hands before applying gloves and after removing gloves. -She did not know the MA had not been performing proper infection control techniques with fingerstick blood sugar checks. -The MA had been trained recently in regards to the infection control policies and the diabetic and insulin protocols.	D 371		

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D 371	Continued From page 34 -It was her expectation MAs would follow appropriate infection control policies, especially with hand sanitizing and items that have come in contact with blood. Review of Staff A's personnel record revealed: -She had received infection control training on 08/28/19. -She completed the diabetic training on 7/17/19. Refer to interview with the previous Director of Nursing on 09/12/19 at 1:34pm. Refer to interview with the interim facility's registered nurse (RN) on 09/12/19 at 3:07pm. Refer to the North Carolina Department of Health and Human Services (NC DHHS) Infection Control Policy. 2. Observation of the medication pass on the second floor of the Assisted Living residence on 09/11/19 at 4:40pm revealed: -Staff C prepared to administer Resident #8's scheduled insulin injection, 5 units of Lantus 100units/ml in one syringe, and 2 units of Humalog 100units/ml sliding scale insulin in a second syringe. -Staff C directed the second resident to her bedroom, sanitized the site, and injected the first syringe of insulin in the right upper arm. -He did not sanitize his hands or wear gloves when performing the subcutaneous injection. -Staff C tossed the capped needle onto the bed and proceeded to sanitize the site and inject the second syringe in the resident's left upper arm. -He tossed the second syringe on the bed and pulled this resident's sleeve down. -Staff C did not sanitize his hands or wear gloves when performing the second subcutaneous	D 371		

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D 371	Continued From page 35 injection. -Staff C grabbed one of the syringes from the bed and proceeded to leave the room. -He was stopped and reminded there was another syringe left behind. -Staff C went back to the bed and located the second syringe. -He returned to the medication cart and documented the procedure. -Staff C did not sanitize his hands after documenting the administration of the insulin. Interview with Staff C on 09/11/19 at 4:45pm revealed: -He was one of the supervisors on the second shift. -Staff C administered medications as needed on second shift. -He had worked at the facility for several years. -Staff C was not sure if it was a facility policy to wear gloves when performing injections, he would have to "look that up." -He did not realize he had not sanitized his hands before and after administering the insulin injections. -Staff C did not remember attempting to leave Resident #8's room without both empty insulin syringes. Observation of the second floor medication cart on 09/11/19 at 4:55pm revealed: -There were disposable gloves available on the side of the medication cart. -There was a bottle of hand sanitizer available on the medication cart. Review of the facility's medication administration policy revealed "Facility staff will administer medications in accordance with infection control measures".	D 371		

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D 371	Continued From page 36 Review of the Staff C's personnel record revealed: -He had received infection control training on 08/28/19. -He had completed the diabetic training on 06/26/19. Refer to interview with the previous Director of Nursing on 09/12/19 at 1:34pm. Refer to interview with the interim facility's Registered Nurse (RN) on 09/12/19 at 3:07pm. Refer to the North Carolina Department of Health and Human Services (NC DHHS) Infection Control Policy. Interview with the previous Director of Nursing on 09/12/19 at 1:34pm revealed: -She instructed all the medication aides on proper infection control procedures in the administration of medications and injections, per the facility's policy. -The policy she and the interim RN followed in their instruction of the MAs was the NC state approved Infection Control Training for Adult Care Homes. -She also instructed the MAs on the annual Diabetic/Insulin training. -The last Diabetic /Insulin Training class she taught was on 06/26/19. -When administering injections, eye drops, nasal sprays, creams etc, the MAs should wash their hands before applying gloves and after removing gloves. -Lancets should be disposed of in the sharps container immediately after the finger has been pierced. -A contaminated test strip should be removed	D 371		

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D 371	Continued From page 37 from the glucometer and placed in the sharps container immediately. Interview with the interim facility's Registered Nurse on 09/12/19 at 3:07pm revealed: -She and the previous Director of Nursing taught the NC state approved Infection Control Training for Adult Care Homes to all the MAs before passing medications. -As taught in both these classes, the MAs should wash their hands and wear gloves before a FSBS and administering insulin injections, and wash their hands after removing gloves. -The MAs should dispose of lancets, alcohol towelettes, test strips, disposable needles and syringes immediately after usage in the sharps container. -The glucometers should be wiped down after usage with a sanitizing towelette and replaced in the case with the residents name on the outside. -She did not know 2 of the staff administering medications did not follow infection control protocols when obtaining FSBS readings and administering insulin injections. Review of North Carolina Department of Health and Human Services Infection Control Policy, page 76, revealed: -Always wear gloves when performing finger sticks, when testing blood for glucose, and when cleaning the blood glucose device. -Discard the used lancet in an approved sharps container at the point of use. -Perform hand hygiene right after you remove your gloves and before touching other residents or things. -You must immediately clean and disinfect surfaces that have been contaminated with blood.	D 371		

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D912	Continued From page 38	D912		
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 ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents (Resident #7) related to a medication for low potassium levels during the 7:40am medication pass on 09/12/19 and 1 of 5 sampled residents (Resident #6) related to a sliding scale insulin order.[Refer to Tag 0358 10A NCAC 13F .1004(a)(1) Medication Administration (Type B Violation)].	D912 10/28/19	Executive Director , Director of Resident Care, and/or Designee shall treat our residents in accordance with the provision of this article. Every resident shall receive care and services which are adequate, appropriate, and in compliance with federal and state laws, and rules and regulations.	
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency	D935		

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	HAL060116	A. BUILDING: _____ B. WING _____	09/12/2019

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SUMMIT PLACE OF SOUTHPARK	2101 RUNNYMEDE LANE CHARLOTTE, NC 28209

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D935	Continued From page 39 Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.	D935	Staff A vacated her position with the company on 9/12/19. Staff D has provided the required training /employment verification and it has been placed in her personnel file in Business Office on 9/16/19.	

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D935	Continued From page 40 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure completion of required 5, 10, or 15 hours of medication aide training or employment verification for 2 of 3 sampled medication aides (Staff A and Staff D). The findings are: 1. Review of Staff A, a medication aide(MA)/supervisor personnel file on 09/12/19 revealed: -She was hired on 06/17/19. -There was documentation of successful completion of the written medication aide exam on 01/25/17. -There was documentation of successful completion of the medication clinical skills list on 06/27/19. -There was no documentation Staff A completed the required 5, 10, or 15 hour medication aide training or completed an employment verification. Review of facility Medication Administration Records (MARs) for July 2019-September 2019 revealed Staff A had documented the administration of medications. Attempted telephone interview with Staff A on 09/12/19 at 3:57pm was unsuccessful. Refer to interview with Business Office Manager (BOM) on 09/12/19.	D935	Business Office Manager, (BOM) ,and/or Designee completed audit for all Medication Aides training and competency evaluation requirements for all Medication Aides to ensure compliance. on 10/11/19. All documentation will be kept in the ED's office in the POC binder. Going forward, BOM,ED, and/or Designee will complete pre-hire requirement checklist to ensure all staff are in compliance with pre-hire documentation on 10/8/19. All documentation will be in the Business Office in staff personnel file for review. An additional Medication Technician training has been scheduled for staff on 10/28, and 10/31/19 for 10/15 hour Medication Administration Training. An additional Medication Technician training has been scheduled for staff on 11/13 and 11/14/19 for 10/15 hour Medication Administration Training. Executive Director , and/or Designee will monitor all new hire required documentation for 12 weeks to ensure compliance. Documentation of monitoring will be maintained in the ED office in the POC book for review. Starting 10/8/19.	

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D935	Continued From page 41 Refer to interview with Administrator on 09/12/19. 2. Review of Staff D, a medication aide, personnel file on 09/12/19 revealed: -She was hired on 07/10/19. -There was documentation of successful completion of the written medication aide exam on 01/27/09. -There was documentation of successful completion of the medication clinical skills list on 07/18/19. -There was no documentation Staff D completed the required 5, 10, or 15 hour medication aide training or completed an employment verification. Review of facility MARs for July 2019-September 2019 revealed Staff D had documented the administration of medications. Interview with Staff D on 09/12/19 at 3:52pm revealed: -She was hired as a MA/personal care aide (PCA) on 07/10/19. -She passed her medication aide exam on 01/27/09, but she did not start working as a MA until 2016. -She completed the 15 hour medication aide training at her previous employer in 2016. -She did not have a copy of the 15 hour medication aide training certificate of completion. -She was not asked to get a copy of the 15 hour medication aide training certificate. -She was not asked to get an employment verification completed. Refer to interview with Business Office Manager (BOM) on 09/12/19. Refer to interview with Administrator on 09/12/19	D935		

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D935	Continued From page 42 at 5:15pm. Interview with the BOM on 09/12/19 at 5:05pm revealed: - She knew the MA position required medication training referred to as "5, 10 or 15 hours" trainings or the completion of the medication aide employment verification. -The nursing department at the facility ensured a newly hired MA met the requirement of having either the certification of completion for the training or a completed medication aide employment verification which reflected the time period the employee worked as a MA. -The facility kept a notebook that contained the medication aide employment verification forms in the Resident Service Director's (RSD) office. -She was not able to locate the notebook nor was she able to provide proof that the 5, 10, or 15-hour MA training was completed by staff. Interview with the Administrator on 09/12/19 at 5:15pm revealed: -She was not aware that staff were missing information in their personnel file regarding the required MA training and the medication aide employment verification. -She knew a notebook was kept in the RSD's office that contained the completed medication aide employment verification forms but also thought the form was kept in the employee's personnel file. -She had searched for the medication aide verification notebook but was unable to locate it. -She thought the BOM was getting copies of MA training certificates. -The RSD did not allow staff to work as a MA without either the completed medication aide	D935		

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D935	Continued From page 43 employment verification form or certificate showing a MA had completed the required training. -Her expectation was the employee personnel files were to contain all required documentation for every position in the facility.	D935		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates	D992		

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D992	Continued From page 44 the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Bases on observations, interviews and record reviews, the facility failed to ensure 1 of 6 staff (Staff D) completed an examination and screening for controlled substances prior to hire. The findings are: Review of Staff D, medication aide, personnel file on 09/12/19 revealed: -She was hired 07/10/19. -The personnel file did not contain documentation of a signed consent for the examination and screenings for controlled substances. -The personnel file did not contain documentation of an examination and screening for controlled substances was completed. Attempted phone interview with Staff D on 09/12/19 at 4:47pm was unsuccessful. Interview with the Business Office Manager on 09/12/19 at 5:05pm revealed: -She knew the requirement that an examination and screening for controlled substances must be completed on new hires. -Her process was to complete an examination and screening for controlled substances the day of the staff 's initial interview. -All hiring managers could administer the	D992	10/31/19 BOM completing audit for examination and screening on all staff to ensure compliance. This will be completed by October 31, 2019. All documentation will be in ED office in POC binder. Staff D documentation of a signed consent from 6/27/2019, was in her personnel file in BOM office. Staff D examination and screening for controlled substances was found in another file in the BOM office. It was completed on 7/8/2019. Going Forward, BOM, ED, and/or Designee will complete pre-hire requirement checklist for all new staff to ensure compliance with pre-hire documentation. All documentation will be in the BOM office in staff personnel file for review. The Executive Director, Director of Resident Care, and /or Designee is responsible for ensuring implementation and ongoing compliance with all components of this plan of corrections and addressing and resolving any variances that may occur. QAPI meeting quarterly by ED, DRC, and/or Designee to review components of this plan of corrections to ensure quality resident care.	

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D992	Continued From page 45 examination and screening for controlled substances test. -Once the examination and screening for controlled substances test was performed, the paperwork with the results were filed in a folder and given to her. -She created an employee file once the pre-hire documents were completed which included the paperwork for a completed examination and screening for controlled substances. -She recalled seeing Staff D's completed examination and screening for controlled substances because it was initially missing a signature and she returned the form to the hiring manager for that signature, but today she could not locate the form. Interview with the Administrator on 09/12/19 at 5:15pm revealed: -She expected the personnel files to contain the required documents which included a signed consent for examination and screening for controlled substances and the results of the screening. -She was unaware that an examination and screening for controlled substances was not in Staff D's personnel file but felt certain it was completed and was just misplaced.	D992		