STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080029	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on February 10, 2022 and February 11, 2022.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#3) who had orders for sliding scale insulin (SSI). The findings are: Review of Resident #3's current FL-2 dated 01/24/22 revealed: -Diagnoses included diabetes, major depressive disorder and cognitive disorder. -There was an order for finger stick blood sugars (FSBS) three times a day. -There was an order for Humalog 100 units/ml Kwikpen inject per sliding scale 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units (a fast acting insulin used to lower elevated blood sugar levels) .	D 358		

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D 358	Continued From page 1 Review of Resident #3's physician's orders dated 02/09/22 revealed: -There was an order for FSBS three times a day. -There was an order for Humalog 100 units/ml Kwikpen inject per sliding scale 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units (a fast acting insulin used to lower elevated blood sugar levels) . Review of Resident #3's record revealed: -There was an order dated 10/07/21 and then was discontinued on 01/10/22, the order for Novolog 100 units/ml inject as per sliding scale subcutaneously 3 times a day: 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units. -There was a subsequent order dated 01/10/ 22 for Humalog 100 units/ml inject as per sliding scale subcutaneously 3 times a day: 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units. Observation of Resident #3's medications on hand 02/10/22 at 1:15pm revealed there were two opened and refrigerated Humalog 100 units/ml Kwikpens dispensed on 01/12/22. Review of Resident #3's December 2021 electronic medication administration record (eMAR) revealed: -FSBS ranged from 99-443. -There was an entry for Novolog 100 units/ml inject as per sliding scale subcutaneously 3 times a day: 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units scheduled for administration at 7:30am, 11:30am and 4:30pm.	D 358		

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ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D 358	Continued From page 2	D 358		

-There was no documentation Novolog was administered for 93 of 93 opportunities from 12/01/21 to 12/31/21.
-There was no space on the eMAR to document the amounts of insulin administered.
-There were 5 entries on 12/02/21, 12/07/21, 2 entries on 12/13/21 and 12/14/21 documented as not administered as, "Withheld per DR/RN orders".
-There was no documentation of refusals.

Review of Resident #3's January 2022 eMAR revealed:
-FSBS ranged from 121-371.
-There was an entry for Novolog 100 units/ml inject as per sliding scale subcutaneously 3 times a day: 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units at 7:30am, 11:30am and 4:30pm and discontinued on 01/12/22.
-There was an entry beginning on 01/12/22 for Humalog 100 units/ml Kwikpen inject per sliding scale 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units at 7:30am, 11:30am.
-There was no documentation Novolog or Humalog was administered for 93 out of 93 opportunities from 01/01/22 to 01/31/22.
-There was no space on the eMAR to document the amounts of insulin administered.
-There was no documentation of refusals or withheld doses.

Review of Resident #3's February 2022 eMAR revealed:
-FSBS ranged from 152-325.
-There was an entry Humalog 100 units/ml Kwikpen inject per sliding scale 151-200=3 units,

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(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 358	Continued From page 3 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units at 7:30am, 11:30am. -There was no documentation Humalog was administered for 28 out of 28 opportunities from 02/01/22 to 02/10/22. -There was no space on the eMAR to document the amounts of insulin administered. -There was no documentation of refusals or withheld doses. Review of Resident #3's record revealed there was no other log or document available for review with documentation of the number of units of sliding scale insulin administered. Based on review of Resident #3's December 2021, January and February 2022 eMARs, it could not be determined whether Novolog and/or Humalog were administered as ordered per sliding scale. Interview with a medication aide (MA) on 02/10/22 at 11:15am revealed: -She was familiar with Resident #3's sliding scale insulin order and would administer the insulin according to her sliding scale. -The eMAR did not have a space to enter the amount of insulin she administered. -She did not inform the Resident Care Director (RCD) or the Administrator that there was no space to document the amount of insulin given to Resident #3. -She did not enter the amount of insulin given according to sliding scale in the eMAR notes. -There was no other paper log to record the amount of insulin given, but she kept her own notes throughout the shift of the amount of insulin she gave residents.	D 358		

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D 358	Continued From page 4 Interview with the RCD on 02/10/22 at 11:20am revealed: -She and the Administrator audited the eMARs weekly. -Resident #3's eMAR had never had a space to document the number of units given for SSI since her employment began in July 2021. -The MAs did not document the number of units of insulin given in the eMAR notes and there were no paper logs to record the number of units given according to the sliding scale, so she just trusted the correct units were administered. -She and the MAs were familiar with Resident #3's sliding scale order for insulin and the number of units to be given according to the sliding scale. -The facility's contracted pharmacy entered medication orders onto the eMARs. -She had never requested pharmacy to create a space in Resident #3's eMAR to document the number of units of insulin given. Telephone interview with a representative from the facility's contracted pharmacy on 02/11/22 at 9:20am revealed: -There was a current order dated 01/10/22 for Humalog 100 units/ml subcutaneously 3 times a day per sliding scale. -There was an order dated 11/16/21 and discontinued 01/12/22 for Novolog 100 units/ml subcutaneously 3 times a day per sliding scale. -The pharmacy entered ordered medications and treatments on the eMAR. -SSI orders normally had a space on the eMAR entry to record the number of units administered. -The entry for Resident #3's Humalog sliding scale was not entered correctly when the Humalog was ordered on 01/10/2022. -There was no documentation that anyone at the facility requested a space to be added for the number of units of insulin given for the Humalog	D 358		

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D 358	Continued From page 5 SSI order. Telephone interview with Resident #3's primary care provider (PCP) on 02/11/22 at 12:23pm revealed: -Resident #3 had a SSI order for Humalog. -He did not know staff had not documented the number of units given per her Humalog sliding scale. -He would expect the facility staff to administer the number of units of Humalog according to her sliding scale order. -If the number of units given was not documented, then he could not be sure how many units were given. Telephone interview with the Administrator on 02/11/22 at 10:25am revealed: -She and the RCD audited eMARs weekly for missed documentation, injection sites and refusals. -She had not noticed and did not know Resident #3's SSI entry on the eMAR did not have a space to document the number of units given. -The pharmacy added orders onto the eMAR and SSI normally had a space to document the number of units given. -MAs did not document the number of units given for sliding scale insulin in any other log. -The facility used paper logs to record residents' FSBS and number of units of insulin given in the past, but stopped when they started using eMARs. -She expected staff to administer SSI as ordered.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 367		

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D 367	Continued From page 6 (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 interviews and record reviews the facility failed to ensure medication administration records were complete and accurate for 1 of 3 sampled resident (#3) with an order for sliding scale insulin (SSI). The findings are: Review of Resident #3's FL-2 dated 01/24/22 revealed: -Diagnoses included diabetes, major depressive disorder and cognitive disorder. -There was an order for finger stick blood sugars (FSBS) three times a day. -There was an order for Humalog 100 units/ml Kwikpen inject per sliding scale 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15	D 367		

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units, 351-400=20 units, BS greater than 400=25 units (a fast-acting insulin used to lower elevated blood sugar levels).

Review of Resident #3's physician's orders dated 02/09/22 revealed:
-There was an order for finger stick blood sugars (FSBS) three times a day.
-There was an subsequent order for Humalog 100 units/ml Kwikpen inject per sliding scale 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units (a fast-acting insulin used to lower elevated blood sugar levels).

Review of Resident #3's record revealed:
-There was a physician's order that discontinued 01/10/22 for Novolog 100 units/ml inject as per sliding scale subcutaneously 3 times a day: 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units.
-There was a subsequent physician's order dated 01/10/22 for Humalog 100 units/ml Kwikpen inject per sliding scale 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units.

Review of Resident #3's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog 100 units/ml inject as per sliding scale subcutaneously 3 times a day: 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units at 7:30am, 11:30am and 4:30pm.
-There was no documentation on the eMAR of the number of units of Novolog administered for 93 of 93 opportunities from 12/01/21 to 12/31/21.

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D 367	Continued From page 8 -There was no space on the eMAR to document the number of units of insulin given per sliding scale. Review of Resident #3's January 2022 eMAR revealed: -There was an entry ending 01/12/22 for Novolog 100 units/ml inject as per sliding scale subcutaneously 3 times a day: 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units at 7:30am, 11:30am and 4:30pm. -There was an entry beginning 01/12/22 for Humalog 100 units/ml Kwikpen inject per sliding scale 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units at 7:30am, 11:30am. -There was no documentation on the eMAR of the number of units of Novolog or Humalog administered for 93 out of 93 opportunities from 01/01/22 to 01/31/22. -There was no space on the eMAR to document the number of units of insulin given per sliding scale. Review of Resident #3's February 2022 eMAR revealed: -There was an entry for Humalog 100 units/ml Kwikpen inject per sliding scale 151-200=3 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, BS greater than 400=25 units at 7:30am, 11:30am. -There was no documentation on the eMAR of the number of units of Humalog administered for 28 out of 28 opportunities from 02/01/22 to 02/10/22. -There was no space on the eMAR to document the number of units of insulin given per sliding scale.	D 367		

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D 367	Continued From page 9 Review of Resident #3's record revealed there was no other log or document available for review with documentation of the number of units of SSI administered. Interview with a medication aide (MA) on 02/10/22 at 11:15 revealed: -She was familiar with Resident #3's SSI order. -She did not remember there being a space to enter the amount of insulin she administered on the eMAR since Resident #3 was admitted in January 2021. -She did not inform the Resident Care Director (RCD) or the Administrator that there was no space to document the amount of insulin given to Resident #3. -She did not enter the amount of insulin given according to sliding scale in the eMAR notes. -There was no other paper log to record the amount of insulin given, but she kept her own notes on scrap paper throughout the shift of the amount of insulin she gave residents and discarded afterward. Interview with the RCD on 02/10/22 at 11:20am revealed: -She and the Administrator audited the eMARs weekly. -Resident #3's eMAR had never had a space to document the number of units given for SSI. -She did not know the number of units given for SSI had to be documented. -The MAs did not document the number of units of insulin given in the eMAR notes and there were no paper logs to record the number of units given according to the sliding scale. -She and the MAs were familiar with Resident #3's sliding scale order for insulin and the number of units to give according to the sliding scale.	D 367		

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-The facility's contracted pharmacy entered medication orders onto the eMARs.
-She had not requested pharmacy to create a space in Resident #3's eMAR to document the number of units of insulin given.

Telephone interview with a representative from the facility's contracted pharmacy on 02/11/22 at 9:20am revealed:
-The pharmacy entered medication orders and treatments onto the eMAR.
-SSI orders normally had a space on the eMAR to record the number of units administered.
-The entry for Resident #3's Humalog sliding scale was not entered correctly when the Humalog was ordered on 01/10/22.
-There was no documentation that anyone at the facility had requested that a space be added to Resident #3's eMAR so the number of units of insulin administered could be documented on the eMAR.

Telephone interview with the primary care provider (PCP) on 02/11/22 at 12:23pm revealed:
-Resident #3 had a SSI order for Humalog.
-He did not know staff had not documented the number of units given as ordered for Humalog sliding scale.
-He would expect the facility staff to document the number of units of Humalog they gave residents.
-If the number of units given was not documented according to the sliding scale order, then he could not be sure how many units were given.

Telephone interview with the Administrator on 02/11/22 at 10:25am revealed:
-She and the RCD audit eMARs weekly for missed documentation, injection sites and refusals.
-She did not know Resident #3's SSI entry did not

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D 367	Continued From page 11 have a space to document the number of units given, she must have missed it when she audited. -Pharmacy added medication orders onto the eMAR and SSI normally had a space for the number of units given. -MAs did not document the number of units given for sliding scale insulin in any other log. -The facility used paper logs to record residents FSBS and number of units of insulin given in the past, but stopped when they started using eMARs.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure a readily retrievable record of controlled substances for 1 of 3 sampled residents (#2) who had orders for a narcotic pain medication. The findings are: 1. Review of Resident #2's current FL2 dated 04/21/21 revealed: -Diagnoses included type 2 diabetes, hypertension, anxiety, heart disease, chronic obstructive pulmonary disease, and insomnia.	D 392		

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D 392	Continued From page 12 -There was an order for tramadol (a narcotic medication used to treat moderate pain) 50mg take 1 tablet three times daily. Review of Resident #2's signed physician's order dated 08/19/21 revealed an order to increase the dose of tramadol to 50mg take 2 tablets (100mg total) three times daily. Review of Resident #2's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for tramadol 50mg take 2 tablets (100mg) three times daily at 8:00am, 2:00pm and 8:00pm. -There was documentation tramadol 100mg was administered three times daily at 8:00am, 2:00pm, and 8:00pm from 12/01/21 through 12/31/21. Review of Resident #2's Controlled Substance Count Sheet (CSCS) from 11/28/21 through 12/18/21 revealed: -The order was for tramadol 50mg take 2 tablets three times daily. -Tramadol 100mg was signed out three times daily from the 8:00am dose on 11/28/21 through the 8:00am dose on 12/18/21. Review of Resident #2's CSCS from 12/18/21 through 12/28/21 revealed: -The order was for tramadol 50mg take 1 tablet three times daily. -A quantity of 90 tablets were dispensed. -Tramadol 50mg was signed out three times daily from the 2:00pm dose on 12/18/21 through the 7:00am dose on 12/28/21 when the count reached 0 tablets remaining. Review of Resident #2's CSCS from 12/29/21	D 392		

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	HAL080029	A. BUILDING: _____ B. WING _____	02/11/2022

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D 392	Continued From page 13	D 392		

through 01/07/22 revealed:
-The order was for tramadol 50mg take 2 tablets three times daily.
-A quantity of 180 tablets were dispensed.
-Tramadol 100mg was signed out three times daily from the 8:00am dose on 12/29/21 through the 8:00pm dose on 01/07/22 when the count reached 0 tablets remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 02/11/22 at 10:50am revealed:
-The CSCS which covered the dates of 12/18/21 through 12/28/21 was from an order dated 07/09/21 for tramadol 50mg take one tablet daily and had been dispensed on 07/14/21 with a quantity of 90 tablets for a 30-day supply.
-On 08/19/21, the pharmacy received an updated order for tramadol to increase dose to two 50mg tablets (100mg total) three times daily.
-They had not received any orders from the facility or the primary care provider (PCP) to adjust the dosage of tramadol during the month of December 2021.
-They had not received any surplus supply of tramadol back from the facility during the month of December 2021.

Interview with a medication aide (MA) on 02/10/22 at 3:00pm revealed:
-She administered tramadol to Resident #2 between 12/18/21 and 12/28/21 when the eMAR order was to give tramadol 50mg 2 tablets three times daily but the CSCS order was for tramadol 50mg 1 tablet three times daily.
-She administered 100mg three times daily as the order in the record and the eMAR reflected.
-She had not noticed the CSCS had a different dose listed on it because she was administering medications based on the order on the

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medication bubble pack from the pharmacy and the order on the eMAR.

Interview with the Resident Care Director (RCD) on 02/11/22 at 8:55am revealed:
-She completed record audits once a week including the CSCS sheets.
-The refill cycle from the pharmacy arrived on the fifth day of each month and she monitored the counts for all controlled substances.
-She had been out of work during part of December 2021 and had not been available to complete the December 2021's CSCS audit; she was unsure if another staff completed the audit in her absence.
-During the time period from 12/18/21 through 12/28/21, Resident #2 received his full dose of tramadol, 100mg three times daily and she did not know why the order on the CSCS was for 50mg three times daily.
-The Administrator kept controlled substances locked in her office for safe keeping until they were needed for dispensing to Resident #2, and she thought the Administrator might have given the MA one of the older CSCS sheets that did not match the tramadol 100mg three times daily bubble pack.
-Since Resident #2 had dose adjustments for his tramadol, he had a surplus of the 50mg tablets and staff had been trying to use those up by giving two tablets three times daily rather than sending the surplus supply back to the pharmacy.
-She had administered tramadol to Resident #2 between 12/18/21 and 12/28/21 and gave him 100mg three times daily.
-She administered the medication based on the order in the record and the order in the eMAR, not the order listed on the CSCS.

Telephone interview with the Administrator on

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D 392	Continued From page 15 02/11/22 on 10:25am revealed: -Whenever Resident #2's tramadol had a dose change, they would place a sticker on the medication bubble pack indicating there had been a change in dosage and to check the eMAR. -They had an overstock of Resident #2's tramadol 50mg tablets so they were trying to use those medication cards up before starting on the new cards from the pharmacy with the current order. -Resident #2 had so many CSCS sheets that she might have given the MA the wrong sheet to document on for the tramadol 100mg three times daily bubble pack. -She conducted eMAR audits with the RCD, but the RCD was responsible for auditing the CSCS before filing them. -She thought maybe the RCD had missed the dose discrepancies in December 2021 with Resident #2's tramadol because she was still training the RCD for the role of RCD during that time. Interview with Resident #2 on 02/11/22 at 11:12am revealed: -He was familiar with the medications he took and aware that tramadol was one of them. -He took a lot of medications and never counted them or checked to see how many tramadol were in his pill cup prior to taking them. -He knew he had some dosage changes but was not sure what the dose changes were. -He did not recall having any increase to his pain level during the month of December 2021. Telephone interview with Resident #2's PCP on 02/11/22 at 11:20 revealed: -He was not aware that from 12/18/21 through 12/28/21 the MA's were documenting administering tramadol 50mg three times daily on the CSCS but tramadol 100mg three times daily	D 392		

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D 392	Continued From page 16 on the eMAR. -There would have been no adverse effect to Resident #2 if he had received tramadol 50mg three times daily instead of tramadol 100mg three times daily as ordered because he had wanted Resident #2 to wean down his dose anyway.	D 392		