	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		BENTH ICATION NOWBER.	A. BUILDING:				
		FCL058008	B. WING			R 05/08/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
FIELDS I	OUNDATION		ND-FIELDS LA STON, NC 27				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	COMPLET	
C 000	Initial Comments		C 000				
	County Department	ensure Section and the Martin t of Social Services completed w up survey on 05/05/23 and					
C 102	10A NCAC 13G .03 Equipment	317 (a) Building Service	C 102				
	10A NCAC 13G .03 Equipment	17 Building Service					
	mechanical, and pl	id all fire safety, electrical, umbing equipment in a family maintained in a safe and					
	This Rule is not me TYPE B VIOLATIO						
	failed to ensure fire maintained in a safe	ions and interviews, the facility safety equipment was e operating condition related r that was not functioning ead battery.					
	The findings are:						
	dated) revealed: -The facility would r equipment in a safe -If the fire equipment facility would call the personnel to repair possible.	ty's Fire Safety Policy (not maintain the fire safety and operating condition. In becomes inoperative, the e proper maintenance equipment as soon as					
	The facility would • ealth Service Regulation	schedule additional staff for					

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         NND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         FCL058008		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 05/08/2023		
ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
	1057 LA	ND-FIELDS LANE				
ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL G REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S           (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECEDED BY FULL           REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCE		ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
Continued From pa	ge 1	C 102				
Review of the facility's fire safety inspection with completion date of 12/08/22 revealed there was documentation of approval with no re-inspection requested.						
-There was an audible beeping of a smoke detector in a resident bedroom off the living room						
-There was a smok and 2 in the hallway facility. -There was a smok -There was no men beeping by staff unt -There was no atter the batteries in the management regar	e detector in the kitchen. tion of the smoke detector til surveyor asked about it. mpt made to test or replace smoke detector or contact ding the need to look into the					
on 05/05/23 at 5:30 -He did not know he had been beeping. -The batteries in the	pm: ow long the smoke detector e smoke detectors were					
05/05/23 at 3:15pm -She had not report beeping. -She had not notice	revealed: ed the smoke detector was d the beeping noise and did					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa the purpose of "fire cannot be immedia Review of the facilit completion date of documentation of a requested. Observation of facil from 8:30am-3:15p -There was an audi detector in a reside area. -There was a smok and 2 in the hallway facility. -There was a smok and 2 in the hallway facility. -There was a smok -There was no men beeping by staff unt -There was no atter the batteries in the management regar matter until prompte Interview with the A on 05/05/23 at 5:30 -He did not know ho had been beeping. -The batteries in the checked yearly and 2022. Interview with the m 05/05/23 at 3:15pm -She had not report beeping. -She had not notice not know how long	OUNDATION         WILLIAM           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)           Continued From page 1           the purpose of "fire watch" if the equipment cannot be immediately repaired.           Review of the facility's fire safety inspection with completion date of 12/08/22 revealed there was documentation of approval with no re-inspection requested.           Observation of facility on 05/05/23 intermittently from 8:30am-3:15pm revealed: -There was an audible beeping of a smoke detector in a resident bedroom off the living room area.           There was a smoke detector in the living room and 2 in the hallway leading to the far end of the facility.           There was a smoke detector in the kitchen.           There was no mention of the smoke detector beeping by staff until surveyor asked about it.           There was no attempt made to test or replace the batteries in the smoke detector or contact management regarding the need to look into the matter until prompted by the surveyor.           Interview with the Assistant to the administrator on 05/05/23 at 5:30pm: -He did not know how long the smoke detector had been beeping.           The batteries in the smoke detectors were checked yearly and were last checked in August 2022.           Interview with the medication aide (MA) on 05/05/23 at 3:15pm revealed: -She had not noticed the beeping noise and did not know how long it had been doing so.           Interview with the facility Manager on 05/08/23 at 3t	OUNDATION         WILLIAMSTON, NC 27           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG           Continued From page 1         C 102           the purpose of "fire watch" if the equipment cannot be immediately repaired.         C 102           Review of the facility's fire safety inspection with completion date of 12/08/22 revealed there was documentation of approval with no re-inspection requested.         C 102           Observation of facility on 05/05/23 intermittently from 8:30am-3:15pm revealed: - There was a mudible beeping of a smoke detector in a resident bedroom off the living room area. - There was a smoke detector in the living room and 2 in the hallway leading to the far end of the facility.         - There was no mention of the smoke detector beeping by staff until surveyor asked about it. - There was no attempt made to test or replace the batteries in the smoke detector or contact management regarding the need to look into the matter until prompted by the surveyor.           Interview with the Assistant to the administrator on 05/05/23 at 5:30pm: -He did not know how long the smoke detector had been beeping. -The batteries in the smoke detectors were checked yearly and were last checked in August 2022.           Interview with the medication aide (MA) on 05/05/23 at 3:15pm revealed: -She had not reported the smoke detector was beeping. -She had not noticed the beeping noise and did not know how long it had been doing so.           Interview with the facility Manager on 05/08/23 at	OUNDATION         WILLIAMSTON, NC         27892           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF C (CROSS-REFERENCED TO T DEFICIENCY           Continued From page 1         C 102         C 102           the purpose of "fire watch" if the equipment cannot be immediately repaired.         C 102           Review of the facility's fire safety inspection with completion date of 12/08/22 revealed there was documentation of approval with no re-inspection requested.         Observation of facility on 05/05/23 intermittently from 8:30am-3:15pm revealed: -There was an audible beeping of a smoke detector in a resident bedroom off the living room and 2 in the hallway leading to the far end of the facility.           -There was a smoke detector in the kitchen. -There was no mention of the smoke detector beeping by staff until surveyor asked about it. -There was no attempt made to test or replace the batteries in the smoke detector or contact management regarding the need to look into the matter until prompted by the surveyor.           Interview with the Assistant to the administrator on 05/05/23 at 5:30pm: -The batteries in the smoke detector swere checked yearly and were last checked in August 2022.           Interview with the medication aide (MA) on 05/05/23 at 3:15pm revealed: -She had not noticed the beeping noise and did not know how long it had been doing so.           Interview with the facility Manager on 05/08/23 at	OUNDATION         WILLIAMSTON, NC 27892           SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MIXE PERFECEDED DE FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF CORRECTIVE ACTION PACTORY (EACH CORRECTIVE ACTION SHOLD BE (ERCH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           Continued From page 1         C 102           Continued From page 1         C 102           Review of the facility's fire safety inspection with completion date of 12/08/22 revealed there was documentation of approval with no re-inspection requested.         C           Observation of facility on 05/05/23 intermittently from 8:30am-3:15pm revealed: -There was a mode detector in the living room area.	

		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		FCL058008	B. WING		R 05/08/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	FOUNDATION	1057 LA	ND-FIELDS LA	NE		
FIELDS	FOUNDATION	WILLIAN	ISTON, NC 27	892		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 102	Continued From pa	ge 2	C 102			
	properly in-case of -He did not rememi detector beeping w 05/05/23 and he the begun on 05/05/23. -He was contacted afternoon about the -Smoke detector ba during the annual fi used batteries that 10 years. -He expected staff including fire safety detectors where su properly immediate Interview with the A on 05/08/23 at 4:50 -He contacted an e the smoke detector 05/05/23 immediate beeping. -He had not noticed beeping and not op Observation of the -Two men entered to were directed to the beeping smoke det -The battery was ch	ber hearing the smoke hen he visited the facility on ought the beeping had just on 05/05/23 in the early as smoke alarm beeping. atteries were checked yearly re inspection but the facility were suppose to be good for to review facility policies, yearly and report any smoke spected of not working ly. assistant to the Administrator opm revealed: lectrician to come and check for proper functioning on ely after being notified of the d the smoke detector was ierating as it should. facility on 05/05/23 at 5:46pm: the facility with a ladder and e resident room with the				
	maintained in safe evidenced by a bee ignored by staff tha failure to ensure the	ensure safety equipment was operating condition as ping smoke detector that was t was present. The facility's e safe operating condition of vas detrimental to the health,				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		FCL058008	B. WING		R 05/08/20	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
IELDS	FOUNDATION		ND-FIELDS LA /ISTON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
C 102	Continued From pa	ge 3	C 102			
	safety and welfare constitutes a Type I	of the residents and 3 Violation.				
		d a plan of protection in S. 131D-34 on 05/05/23 for				
	THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 22, 2023.					
C 132	10A NCAC 13G. 04 Medication Staff	03(b) Qualifications Of	C 132			
	except persons aut licensure laws to ac complete six hours	es and their direct supervisors horized by state occupational dminister medications, shall of continuing education medication administration.				
	This Rule is not me					
	facility failed to ens	s and record reviews, the ure staff administering e required 6 hours of annual				
	The findings are:					
		A's personnel record revealed: 03/12/21 as a medication aide				

	of Health Service Re						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			E SURVEY PLETED	
		FCL058008	B. WING			R 05/08/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
FIELDS I	OUNDATION		D-FIELDS LA STON, NC 27				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLETI DATE	
C 132	Continued From pa	ge 4	C 132				
	-She completed 15 on 05/21/21.	hour medication aide training					
		tation she passed the					
	Medication Aide exa						
		Medication Administration					
	Clinical Skills Chec						
		entation of 1 hour of continuing					
		medication administration					
	mental health speci	)/22 by a local geriatric/adult alty team.					
	Review of a resider	nt's medication administration					
	record for April 2023 revealed Staff A						
	administered medic	cations 18 of 31 days.					
	Interview with Staff revealed :	A on 05/08/23 at 11:20am					
		cation training once in awhile					
		nber when she last received					
	medication training.						
		he received 6 hours of					
	medication training						
		δ hours of continuing					
	education for medic	cation was required each year.					
		<i>i</i> ith the Facility Manager on					
	05/08/23 at 4:00pm						
	Refer to interview w	/ith the Assistant to the					
	Administrator on 05	5/08/23 at 5:15pm.					
		s personnel record revealed:					
	-She was hired on (						
		tation she passed the					
	Medication Aide exa						
	•	Medication Administration					
	Clinical Skills Chec	entation of 1 hour of continuing					
		medication administration					
		)/22 by a local geriatric/adult					

	of Health Service Re T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI F	CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
					R		
		FCL058008	B. WING			05/08/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
	FOUNDATION		D-FIELDS LA				
		WILLIAMS	STON, NC 27	7892			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
C 132	Continued From pa	ige 5	C 132				
	mental health spec	ialty team					
	-There was documentation of a 3 hour training on						
	nebulization and inl	halers on 04/20/22.					
	Review of a resider	nt's medication administration					
	record for April 202						
	administered medic	cations 12 of 31 days.					
	Interview with Staff	B on 05/08/23 at 1:25pm					
	revealed:	2 011 00/00/20 at 1120p111					
		e other MAs in the facility.					
		e she needed to have 6 hours					
	continuing education	δ hours of management on each year					
		ember the last time she					
		education for medications.					
	-She had not received management.	ved continuing education for					
	management.						
	Refer to interview v 05/08/23 at 4:00pm	vith the Facility Manager on 1					
	Refer to interview v Administrator on 05	vith the Assistant to the 5/08/23 at 5:15pm.					
		C's personnel record revealed:					
	-She was hired on	07/21/19 as a MA.					
	-She completed 15 training on 07/12/19	hours of medication aide					
		entation he passed the					
	Medication Aide ex						
		e Medication Administration					
	Clinical Skills Chec	klist on 07/12/19. entation of 1 hour of continuing					
		o medication administration					
		0/22 by a local geriatric/adult					
	mental health spec						
	Review of a resider	nt's medication administration					
	record for April 202						
ision of H	ealth Service Regulation		h			1	

Division	of Health Service Re	gulation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		FCL058008	B. WING			R <b>08/2023</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FIELDS	FOUNDATION		ND-FIELDS LA			
			ISTON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 132	Continued From pa	ge 6	C 132			
	administered medic	cations 13 of 31 days.				
	Refer to interview with the Facility Manager on 05/08/23 at 4:00pm					
	Refer to interview with the Assistant to the Administrator on 05/08/23 at 5:15pm.					
	4:00pm revealed: -He was responsibl the staff. -He thought MAs w of continuing educa -He used to schedu health team but the over the past year.	ile trainings with a local menta team had become unreliable ad been more trainings but he	1			
	on 05/08/23 at 5:15 -The Administrator responsible for sch	ssistant to the Administrator opm revealed: and the facility Manager were eduling trainings for the staff. hen trainings were conducted.				
	Refer to Tag 330 10 Medication Adminis	DA NCAC 13G .1004(a) tration.				
	Refer to Tag 330 10 Medication Adminis	DA NCAC 13G .1004(j) tration.				
	received 6 hours of each year for medic medications includi as insulin by injection ensure 6 hours of co detrimental to the h	ensure medication aides continuing education credits cation aides that administered ng high risk medication such on. The facility's failure to continuing education was ealth, safety and welfare of nstitutes a Type B Violation.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		FCL058008	B. WING		05/08/2023	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IELDS	FOUNDATION		ND-FIELDS LA /ISTON, NC 27			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
C 132	Continued From pa	ge 7	C 132			
		d a plan of protection in S. 131D-34 on 05/08/23 for				
		N DATE FOR THE TYPE B NOT EXCEED JUNE 22,				
C 134	10A NCAC 13G .04 Supervisor-In-Char		C 134			
		10A NCAC 13G .0402 Qualifications of Supervisor-In-Charge				
	the administrator fo family care home in administrator, shall requirements:	-	a			
	the effective date of (2) the supervisor-in after August 1, 199 graduate or certified passed the alternat by the Department	Ider, if employed on or after f this Rule; n-charge, employed on or 1, shall be a high school d under the GED Program or ive examination established of Health and Human e effective date of this Rule;				
	and (3) earn 12 hours a credits related to th	year of continuing education e management of adult care aged and disabled persons.				
	This Rule is not me TYPE B VIOLATIO					

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED	
		FCL058008	B. WING			R 05/08/2023	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
FIELDS I	FOUNDATION		ND-FIELDS LA ISTON, NC 27				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
C 134	Continued From pa	ge 8	C 134				
	facility failed to ensireceived 12 hours of	s and record reviews, the ure the Supervisor in Charge of continuing education related adult care homes and care of led persons.					
	The findings are:	The findings are:					
	-She was hired on ( (MA). -She completed the Clinical Skills Chec -There was docume education related to conducted on 03/30 mental health spec -There was docume nebulization and inf -There was docume Building education	entation of 1 hour of continuing o medication administration 0/22 by a local geriatric/adult ialty team. entation of a 3 hour training on nalers on 04/20/22. entation of a 1 hour Team on 09/28/22.					
	revealed: -She supervised the -It was her respons orders were implem administered as ord their scheduled app -Staff concerns were would notify the fact to the Administrator not available due to -She was not aware of continuing educations -She had not receive	re reported to her and she ility Manager or the Assistant since the Administrator was a medical concern. she needed to have 12 hours	5				
	Interview with the F 4:00pm revealed:	acility Manager on 05/08/23 at	t				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		FCL058008	B. WING		R 05/08/2023	
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
IELDS I	OUNDATION		ND-FIELDS LA			
			STON, NC 27	PROVIDER'S PLAN OF (		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
C 134	Continued From pa	ge 9	C 134			
	the staff. -He thought MAs we of continuing educat know 6 hours in mat the Supervisor in C -He thought there h did not know when Interview with the A on 05/08/23 at 5:15 -The Administrator responsible for sche -He was not aware required for the Sup -He did not know with The facility failed to	ad been more trainings but he they happened. ssistant to the Administrator pm revealed: and the facility Manager were eduling trainings for the staff. 6 hours in management were				
	medications includi as insulin by injection ensure 6 hours of c detrimental to the h the resident and co The facility provided	cation aides that administered ing high risk medication such on. The facility's failure to ontinuing education was ealth, safety and welfare of institutes a Type B Violation.				
		N DATE FOR THE TYPE B NOT EXCEED JUNE 22,				
C 185	10A NCAC 13G .06 Staff	01(a) Management and Other	C 185			
	10A NCAC 13G .06 Staff	01Mangement and Other				

	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
		FCL058008	B. WING			R 05/08/2023	
	PROVIDER OR SUPPLIER	1	DRESS, CITY, ST				
			ID-FIELDS LA				
FIELDS	FOUNDATION	WILLIAM	STON, NC 27	892			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
C 185	Continued From pa	age 10	C 185				
	responsible for the home and shall also Division of Health S county department and maintaining the The co-administrate share equal respon for the operation of and maintaining the The term administrate	ome administrator shall be total operation of a family care o be responsible to the Service Regulation and the of social services for meeting e rules of this Subchapter. or, when there is one, shall usibility with the administrator the home and for meeting e rules of this Subchapter. ator also refers to here it is used in this					
	This Rule is not mo TYPE B VIOLATIO	-					
	interviews, the Adm total operation of th areas related to bui medication adminis	ions, record reviews and ninistrator failed to ensure the ne facility to meet the rule ilding service equipment, stration, qualifications of e and qualifications of					
	The findings are:						
	-The facility was lice capacity of 6 ambu	ty's license revealed: ensed effective 01/01/23 for a latory residents. e of the facility's license was					
vision of L	05/05/23 at 8:30am -Six residents were	e at the facility. de (MA) was present.					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		FCL058008	B. WING			R 05/08/2023	
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
IELDS	FOUNDATION		ND-FIELDS LA				
			ISTON, NC 27				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
C 185	Continued From pa	ge 11	C 185				
	revealed: -The SIC was the S she reported any is: -The Administrator I absence but she co Interview with the S revealed: -She was the Super the facility. -Staff concerns wer would notify the fac to the Administrator not available. -She was not aware of her work role but meetings to discuss Interview with the fa 10:05am revealed: -The Administrator weekly prior to Mare -He and the Assista the duties of the Ad she had been out. -Staff would call hin Assistant to the Adr available. -He expected the Adr end on May 2023. -They had not looke Administrator since to return to duties w absent.	had been on a leave of build not say how long. IC on 05/08/23 at 1:25pm rvisor in Charge for the MAs a re reported to her and she ility Manager or the Assistant since the Administrator was e of any process for oversight the facility had monthly staff s concerns that came up. acility Manager on 05/08/23 at was in the facility at least ch 2023. Int to the Administrator took or ministrator temporarily since n first but could always call the ministrator or return at the ed for a temporary the Administrator was going <i>v</i> ithin a few months of being ssistant to the Administrator					

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		FCL058008	B. WING			R 05/08/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE			
FIELDS I	FOUNDATION		D-FIELDS LA STON, NC 27				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
C 185	Continued From pa absence since Mar	-	C 185				
	<ul> <li>-He and the facility facility temporarily of to return.</li> <li>-He lived next door out of the facility aluent -He and the facility and -He and the facility available by phone that came up.</li> <li>-He had "good staff doing what was reconstructed -Oversight of staff H have since the Adm 2023 and things had Non-compliance was rule areas:</li> <li>1. Based on observe facility failed to ensign maintained in a saff to a smoke detector properly due to a doi:</li> </ul>	Manager were managing the until the Administrator was able to the facility and was in and most daily. Manager were always for staff questions or issues f" and he thought they were quired in the facility. had not been what it should hinistrator went out in March id fallen through the cracks. as identified in the following vations and interviews, the ure fire safety equipment was e operating condition related or that was not functioning ead battery. [Refer to Tag 102 B17(a) Building Service					
	facility failed to ens medications had th training for medicat Tag 132 10A NCAC	ews and record reviews, the ure staff administering r required 6 hours of annual tion administration. [Refer to C 13G .0403(b) Qualifications (TYPE B VIOLATION)].					
	facility failed to ens staff that were adm required 6 hours of management annu NCAC 13G .0402 0	ge (TYPE B VIOLATION)].					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED R	
		FCL058008	B. WING			08/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FIELDS I	OUNDATION		ND-FIELDS LA ISTON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
C 185	Continued From pa	ige 13	C 185			
	reviews, the facility medications as ord #3) that were presc #3) and a short acti administered by inju	vations, interviews and record failed to administer ered for 2 of 3 residents (#1, cribed long-acting insulin (#1, ing insulin (#3) to be ection. [Refer to Tag 330 10A a) Medication Administration DN)].				
	reviews, the facility medication adminis for 1 of 3 sampled in dose changes order control blood sugar	vations, interviews, and record failed to ensure the stration records were accurate residents (#3) who had severa ared for a medication used to c. [Refer to Tag 342 10A NCAC sation Administration (TYPE B	I			
	facility failed to ens physician's order w residents (#1, #2, # medications used to injection (#1, #2, #3	ew and record reviews, the ure an assessment and as in place for 3 of 3 sampled (3) who self-administered o control blood sugar by B). [Refer to Tag 350 10A Self-Administration of lard Deficiency)].				
	management and te evidenced by failure compliance with the Adult Care Homes, equipment, medica qualifications of sup qualifications of me detrimental to the h	ailed to ensure the overall otal operations of the facility as e to maintain substantial e rules and statutes governing related to building service tion administration, pervisor in charge and edication staff. This failure iealth, safety and welfare of onstitutes a Type B Violation.	5			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
						R
		FCL058008	B. WING		05/	08/2023
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S <sup>-</sup> N <b>D-FIELDS LA</b>			
FIELDS	FOUNDATION		ISTON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 185	Continued From pa	ge 14	C 185			
	accordance with G. this violation.	S. 131D-34 on 05/08/23 for				
		TE FOR THE TYPE B NOT EXCEED JUNE 22,				
C 330	10A NCAC 13G .10 Administration	04(a) Medication	C 330			
	<ul> <li>(a) A family care he preparation and add prescription and no by staff are in accounce (1) orders by a licer which are maintained</li> </ul>	04 Medication Administration ome shall assure that the ministration of medications, n-prescription and treatments rdance with: nsed prescribing practitioner ed in the resident's record; and tion and the facility's policies	Ł			
	This Rule is not me TYPE A2 VIOLATIC					
	reviews, the facility medications as orde were prescribed lor	ons, interviews and record failed to administer ered for 2 of 3 residents that ng-acting insulin (#1, #3) and a (#3) to be administered by				
	The findings are:					
	Policy (not dated) re -Medications should accordance with the orders.	ty's Medication Administration evealed: d be administered in e prescribing practitioner's monstrated competency				

	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	E CONSTRUCTION	COM	E SURVEY PLETED
		FCL058008	08 B. WING		R 05/08/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IELDS I	FOUNDATION		ND-FIELDS LA /ISTON, NC 27			
(X4) ID PREFIX	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	FION SHOULD BE	(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC		DATE
C 330	Continued From pa	ige 15	C 330			
	according to State rules may prepare and administer medications.					
	02/01/23 revealed:	ent #3's current FL-2 dated				
	-Diagnoses include -There was no info orientation status.	d diabetes type II. rmation documented for				
		t #3's Resident Register sion date of 04/01/19.				
		t #3's Licensed Health ort (LHPS) dated 04/03/23				
	Nurse (RN).	ned by the facility's Registered	d			
		ulin and oral glycemic				
	-There was no doc	ed blood glucose monitoring. umentation for LHPS task of cations by injection.				
	05/05/23 at 11:56a	rolog administration on m revealed: (Novolog is a used to control blood sugar				
	-The medication aid the Novolog pen ar	de (MA) put a new needle on nd dialed up 14 units before Log pen in front of Resident				
	-Resident #3 reque the injection. -The MA washed h	sted assistance to administer er hands and donned gloves				
	before picking up th -The MA removed that covered the ne	1 cap to reveal a smaller cap				
	-The MA placed the	e capped needle to Resident pressed the pen to administer				

Division	of Health Service Re	egulation			1.014	APPROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		FCL058008	B. WING			R 08/2023
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	FOUNDATION	1057 LAI	ND-FIELDS LA	NE		
FIELDS	FOUNDATION	WILLIAN	ISTON, NC 27	892		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 330	Continued From pa	ige 16	C 330			
	the medication.	and discarded the capped				
	revealed: -She thought the Na administering the in administered throug needle. -She did not know t needle needed to b administration of th -Resident #3's Nove in the same type need -Both insulins were without removing th needle. -She thought the sr during administration injection did not hur Review of Resident	e medication. olog and Lantus insulins were en delivery system and used dles. administered the same way he small cap that covered the mall cap remained in place on for safety and so the				
	(According to the A a hemoglobin A1C prediabetes and a	merican Diabetes Association, value of 5.7 to 6.4 is value of 6.5 and above is in the goal range for people living				
		t #3's lab report for 03/31/23 globin A1C was 8.5.				
ivision of L	2023 revealed: -There was docume fingerstick blood su	t #3's flowsheet for February entation Resident #3's Igar (FSBS) was checked four preakfast, lunch, dinner and				

	of Health Service Re					
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		FCL058008	B. WING			R 08/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
FIELDS	FOUNDATION		ND-FIELDS LA ISTON, NC 27			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	COMPLETE
C 330	Continued From pa	ge 17	C 330			
	breakfast. -The FSBS ranged -The FSBS ranged dinner. -The FSBS ranged Review of Resident 2023 revealed: -There was docume was checked four till lunch, dinner and b -The FSBS ranged breakfast. -The FSBS ranged	from 100 to 146 before from 123 to 269 before lunch. from 168 to 423 before from 150 to 344 at bedtime. #3's flowsheet for March entation Resident #3's FSBS mes each day at breakfast, edtime. from 106 to 194 before from 137 to 276 before lunch. from 144 to 366 before				
	Review of Resident revealed: -There was docume was checked four ti lunch, dinner and b -The FSBS ranged breakfast. -The FSBS ranged dinner. -The FSBS ranged	from 125 to 359 at bedtime. #3's flowsheet for April 2023 entation Resident #3's FSBS mes each day at breakfast, edtime. from 106 to 194 before from 137 to 276 before lunch. from 144 to 366 before from 125 to 359 at bedtime.				
	revealed: -There was docume was checked four ti lunch, dinner and b -The FSBS ranged breakfast. -The FSBS ranged	entation Resident #3's FSBS mes each day at breakfast,				

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
			A. BUILDING.			
		FCL058008	B. WING	B. WING		R 08/2023
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IELDS	FOUNDATION		ND-FIELDS LA ISTON, NC 27			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
C 330	Continued From pa	ge 18	C 330			
	-The FSBS ranged	from 103 to 314 at bedtime.				
	02/01/23 revealed a	ent #3's current FL-2 dated a physician's order for Novolog b be administered by injection a and breakfast.	3			
	10/12/22 revealed N	#3's physicians order dated Novolog 10 units, to be ection with breakfast and lunch	ו			
	12/28/22 revealed a to 12 units with brea	#3's physicians order dated an order to increase Humalog akfast and lunch each day. acting insulin used to control				
	03/31/23 revealed: -Humalog 14 units v injection with break -There was docume	#3's physicians order dated were to be administered by fast and lunch each day. entation that Novolog could be n insurance coverage.				
	revealed: -There was a comp Flexpen 12 units to breakfast and lunch -There was docume	rd (MAR) for March 2023 outerized entry for Novolog be administered with n. entation of administration each	1			
	03/31/23. Review of Resident revealed: -There was a comp	12:00pm from 03/01/23 to #3's MAR for April 2023 puterized entry for Novolog				
	Flexpen 12 units to breakfast and lunch ealth Service Regulation	be administered with n.				

FCL058008         B. WING         C. MING         C. MING         C. MING           1057 LAND-FIELDS LANE WILLIAMSTON, NC 27892         1057 LAND-FIELDS LANE WILLIAMSTON, NC 27892         C. MING         MING         C. MING		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY PLETED
Bit Dumbartion           Description           OPEN INFORMATION         Description of the Description of Description of the Description of			FCL058008	B. WING	B. WING		
PHELDS FOUNDATION         WILLIAMSTON, NC 27892           (24) Dig         (EACH DEFICIENCY MUST DE PRECIENCIES (EACH DEFICIENCY MUST DE PRECIENCIES) (EACH DEFICIENCY MUST DE PRECIENCIES) (EACH DEFICIENCY MUST DE PRECIENCIES) (EACH DEFICIENCY MUST DE PRECIENCY RESOLUTION ON LSC IDENTIFYING INFORMATION)         D PRETX TAS         D PROVIDERS TUP ACTION SHOULD BE (EACH DEFICIENCY DEFICIENCY)         D DEFICIENCY)         D DEFICIENCY)         D DEFICIENCY           C 330         Continued From page 19 The 12 was marked through and 14 was handwritten above the entry with handwritten instructions to start 03(31/23). There was a documentation of administration each day at 8:00am and 12:00pm from 04/01/23 to 04/30/23.         C 330         C 330         Image: Control of Control of Control (CAC) Contro (CAC) Contro (CAC) Control (CAC) Control (CAC) Control (CAC) Cont	NAME OF F	PROVIDER OR SUPPLIER					
Preferix TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIENTIFYING INFORMATION)       PREFIX TAG       (EACH DEFICIENCY CT USE ATTENDED INFORMATION)       PREFIX TAG       (EACH DEFICIENCY CT USE ATTENDED INFORMATION)       C330         C 330       Continued From page 19       C 330       C 330       C 330       C 330         -The 12 was marked through and 14 was handwritten above the entry with handwritten instructions to start 03/31/23.       C 330       C 330       C 330         -There was documentation of administration each day at 8:00am and 12:00pm from 04/01/23 to 04/30/23.       Review of Resident #3's MAR for May 2023 revealed:       -There was a computerized entry for Novolog Flexpen 14 units to be administered with breakfast and lunch.       -There was a computerized entry for Novolog Flexpen 14 units to be administered with breakfast and lunch.       -There was documentation Novolog Flexpen 14 units was administered each day at 8:00am on 05/08/23 at 05/05/23 at at 12:00pm on 05/01/23 to 05/04/23.       Refer to telephone interview with the Registered Nurse (RN) for the facility Manager on 05/08/23 at 4:45pm.         D. Review of Resident #3's current FL-2 dated 02/01/23 revealed a physician's order for Novolog Flexpen, 14 units to be administered each day with dinner.       Eview of Resident #3's physicians order dated 10/12/22 revealed Novolog Flexpen 12 units was to be administered by injection with dinner.       Eview of Resident #3's physicians order dated 12/22/22/22 revealed an order to increase Humalog to 14 units with dinner.	FIELDS I	OUNDATION					
<ul> <li>The 12 was marked through and 14 was handwritten above the entry with handwritten instructions to start 03/31/23.</li> <li>There was documentation of administration each day at 8:00am and 12:00pm from 04/01/23 to 04/30/23.</li> <li>Review of Resident #3'S MAR for May 2023 revealed:</li> <li>There was a computerized entry for Novolog Flexpen 14 units to be administered with breakfast and lunch.</li> <li>There was documentation Novolog Flexpen 14 units was administered each day at 8:00am on 05/01/23 to 05/05/23 and at 12:00pm on 05/01/23 to 05/04/23.</li> <li>Refer to telephone interview with the Registered Nurse (RN) for the facility Manager on 05/08/23 at 4:45pm.</li> <li>Refer to interview with the Assistant to the Administrator on 05/08/23 at 5:15pm.</li> <li>D. Review of Resident #3's current FL-2 dated 02/01/23 revealed a physician's order for Novolog Flexpen, 14 units to be administered each day with dinner.</li> <li>Review of Resident #3's physicians order dated 10/12/22 revealed Nurse to interview with the Administered each day with dinner.</li> <li>Review of Resident #3's physicians order dated 12/28/22 revealed an order to increase Humalog to 14 units with dinner.</li> </ul>	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	COMPLET
handwritten above the entry with handwritten instructions to start 03/31/23.         -There was documentation of administration each day at 8:00am and 12:00pm from 04/01/23 to 04/30/23.         Review of Resident #3's MAR for May 2023 revealed:         -There was a computerized entry for Novolog Flexpen 14 units to be administered with breakfast and lunch.         -There was documentation Novolog Flexpen 14 units was administered each day at 8:00am on 05/01/23 to 05/05/23 and at 12:00pm on 05/01/23 to 05/04/23.         Refer to telephone interview with the Registered Nurse (RN) for the facility on 05/05/23 at 4:05pm.         Refer to interview with the facility Manager on 05/08/23 at 4:45pm.         Refer to interview with the facility Manager on 05/08/23 at 4:45pm.         b. Review of Resident #3's current FL-2 dated 02/01/23 revealed a physician's order for Novolog Flexpen, 14 units to be administered each day with dinner.         Review of Resident #3's physicians order dated 10/12/22 revealed Novolog Flexpen 12 units was to be administered by injection with dinner.         Review of Resident #3's physicians order dated 12/28/22 revealed an order to increase Humalog to 14 units with dinner.	C 330	Continued From pa	ige 19	C 330			
to 14 units with dinner.		handwritten above finstructions to start -There was docume day at 8:00am and 04/30/23. Review of Resident revealed: -There was a comp Flexpen 14 units to breakfast and lunch -There was docume units was administe 05/01/23 to 05/05/2 to 05/04/23. Refer to telephone Nurse (RN) for the Refer to interview w 05/08/23 at 4:45pm Refer to interview w Administrator on 05 b. Review of Resident 10/12/22 revealed a Flexpen, 14 units to with dinner. Review of Resident 10/12/22 revealed a Review of Resident	the entry with handwritten 03/31/23. entation of administration each 12:00pm from 04/01/23 to t #3's MAR for May 2023 outerized entry for Novolog be administered with n. entation Novolog Flexpen 14 ered each day at 8:00am on 23 and at 12:00pm on 05/01/23 interview with the Registered facility on 05/05/23 at 4:05pm. with the facility Manager on n. with the facility Manager on n. with the Assistant to the 5/08/23 at 5:15pm. ent #3's current FL-2 dated a physician's order for Novolog b e administered each day t #3's physicians order dated Novolog Flexpen 12 units was by injection with dinner. t #3's physicians order dated				

	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		FCL058008			05/	08/2023
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST ND-FIELDS LA			
FIELDS	FOUNDATION		ISTON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 330	Continued From pa	ige 20	C 330			
		Humalog 16 units was to be ection each evening with				
	revealed: -There was a comp Flexpen 14 units to -There was docume	t #3's medication rd (MAR) for March 2023 buterized enter for Novolog be administered with dinner. entation of administration each 0 03/01/23 to 03/31/23.	1			
	revealed: -There was a comp Flexpen 14 units to -The 14 was marked handwritten above instructions to start -There was docume	t #3's MAR for April 2023 puterized entry for Novolog be administered with dinner. ed through and 16 was the entry with handwritten 03/31/23. entation of administration each 0 04/01/23 to 04/30/23.	n			
	revealed: -There was a comp Flexpen 14 units to -There was docume	t #3's MAR for May 2023 buterized entry for Novolog be administered with dinner. entation Novolog Flexpen 14 ered each day at 5:00pm on 23.				
		interview with the Registered facility on 05/05/23 at 4:05pm.				
	Refer to interview w 05/08/23 at 4:45pm	vith the facility Manager on ı.				
	Refer to interview w Administrator on 05	vith the Assistant to the 5/08/23 at 5:15pm.				
	c. Review of Reside	ent #3's current FL-2 dated				

	of Health Service Re					
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		FCL058008	B. WING			R 08/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE. ZIP CODE	•	
			ND-FIELDS LA			
FIELDS	FOUNDATION	WILLIAM	ISTON, NC 27	7892		
(X4) ID	_	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
C 330	Continued From pa	ge 21	C 330			
	02/01/23 revealed a	a physician's order for				
		be administered each night				
		lar is a long-acting insulin				
	used to control bloc					
	Review of Resident	#3's physicians order dated				
		antus was to be increased to				
	38 units each day.(I	Lantus is a long-acting insulin				
	used to control bloo	od sugar levels.)				
	Review of Resident	#3's physicians order dated				
		antus was to be increased to				
	40 units each day.					
	Review of Resident	#3's physicians order dated				
		antus was to be increased to				
	42 units each day.					
	Review of Resident	#3's physicians order dated				
		antus 46 units was to be				
	administered each	day.				
	Review of Resident	#3's medication				
		rd (MAR) for March 2023				
	revealed:					
		uterized entry for Basaglar 38				
		ed through with a hand writter	ו			
		be administered with dinner.				
		entation of administration each 03/01/23 to 03/31/23.	1			
		00/01/2010 00/01/20.				
	Review of Resident	#3's MAR for April 2023				
	revealed:					
		uterized entry for Basaglar 38				
		ered every day and was				
	scheduled for 8:00p	om d through, and a hand written				
		d through with a hand written				
		the units to be administered.				
		entation of administration each				

	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(23) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		FCL058008	B. WING			R 08/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		1057 LA	ND-FIELDS LA	NE		
FIELDS	FOUNDATION	WILLIAN	ISTON, NC 27	892		
PREFIX (EACH DEFICIENC)		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
C 330	Continued From pa	ge 22	C 330			
	day at 5:00pm from	04/01/23 to 04/30/23.				
	revealed: -There was a comp with hand written 46 each day.	#3's MAR for May 2023 uterized entry for Basaglar 5 units to be administered entation Basaglar 46 units was				
		day at 8:00pm on 05/01/23 to				
	revealed: -Her FSBS ran high -She gave herself in sometimes the staf -Her insulins were i the staff would dial medication before g herself.	f would do it. n a pen delivery system and in the dose for each giving she gave the injection to				
	covering the needle removed the small medication before 0 -She woke up on 0 she was pouring sw floating.	5/07/23 and didn't feel well; veat and felt like she was				
	asked the MA to wa as they walked to th	and she was given orange				
	care provider's (PC 9:25am revealed: -Resident #3 was d was uncontrolled.	N for Resident #3's primary P) office on 05/08/23 at iagnosed with diabetes that				
		rt acting insulins had been mes in an effort to control the				

TATEMENT OF DEFIC ND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL058008	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 05/08/2023	
AME OF PROVIDER (	)r supplier		DDRESS, CITY, ST		03/	00/2023
		1057 LA	ND-FIELDS LA	NE		
			ISTON, NC 27			
PREFIX (EAC	H DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 330 Continu	ed From pa	ge 23	C 330			
-Uncont blood ve -Blood s to dizzir -Blood s to diabe breakdo become -Blood s be life th Interview on 05/00 -Reside acting ir via a pe -Whethe Basagla what ins medicat -Not reo cause b -Uncont vessels heart pr Second 1:25pm -Reside system the date -She tho	essels incluc ugar levels ess, falls an ugar levels tic ketoacido wn of fat too toxic, requi ugars that r areatening. v with the fa 3/23 at 2:15p nt #3 was or sulins that v n device on er Resident ; r and Huma urance wou ions were us eiving the in lood glucose rolled diabei that could le oblems such interview wi revealed: nt #3 had be for quite a w ought the face every 3 mor alle was not is I not ask for	#3 received Lantus or log or Novolog depended on ld agree to pay for and the sed interchangeably. Isulins as ordered would to not be controlled. tes caused damage to blood ead to decreased vision and	/			

	of Health Service Re		()(0)	CONCEPTION			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		FCL058008	B. WING			R 05/08/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
FIELDS	FOUNDATION		ID-FIELDS LA STON, NC 27				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)	
PREFIX TAG	· ·	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
C 330	Continued From pa	ige 24	C 330				
	to 300's range. -She thought Resid been dispensed in a syringe when she b one and a half year -She completed dia taught by the facility include the administ signs and symptom sugar was too high -She received training administration of ina did not remember w -The training using included putting a ra- did not include unca injection. -She had administer acting insulins to that type delivery syster -She did not know the re- medications throug -The facility RN corr and she (MA) admi 05/06/23 and 05/07 -Resident #3 rang h she did not feel well -Resident #3 was w found to be 50 at all -She gave Residen grapes and recheck result of 100.	ing from the RN on the sulin using the pen, but she when that training was. the pen delivery system new needle on each time but apping the needle prior to ered both the long and short e residents using the same in that used the same needles. there was a second cap over ided to be removed and she sidents did not receive the h the capped needle. inducted a training on 05/05/23 nistered medications on 7/23. her call bell on 05/07/23 saying ll. tery sweaty and her FSBS was bout 8:55am. t #3 orange juice and some ked her FSBS at 10:00am with he interview with Resident #3's ler (PCP) on 05/08/23 at					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		COM	E SURVEY PLETED	
		FCL058008	B. WING			R 05/08/2023	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
FIELDS I	FOUNDATION		ND-FIELDS LA ISTON, NC 27				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
C 330	Continued From pa	ge 25	C 330				
		interview with the Registered facility on 05/05/23 at 4:05pm.					
	Refer to interview with the facility Manager on 05/08/23 at 4:45pm.						
	Refer to interview v Administrator on 05	vith the Assistant to the 5/08/23 at 5:15pm.					
	06/30/22 revealed: -Diagnoses include -There was docume disoriented. -There was an order (FSBS) checks thre -There was an order units to be administ	entation he was intermittently er for fingerstick blood sugar ee times each day. er for Tresiba FlexTouch 38 tered by injection each day at					
	lower blood glucose Review of Resident	s a long acting insulin used to e.) t #1's current assessment and 5/22 revealed Resident #1					
		ant on staff assistance for					
	06/14/22 revealed a (According to the A a hemoglobin A1C prediabetes and a	t #1's lab report dated a hemoglobin A1C of 6.0. merican Diabetes Association, value of 5.7 to 6.4 is value of 6.5 and above is in the goal range for people living s than 7.)					
		t #1's lab report dated a hemoglobin A1C of 6.4.					
	Review of Resident administration reco	t #1's medication rd (MAR) for March 2023					

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		FCL058008	B. WING		R 05/08/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FIELDS	FOUNDATION		D-FIELDS LA			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
C 330	Continued From pa	ge 26	C 330			
	FlexTouch 38 units bedtime. -There was docume	uterized entry for Tresiba to be injected each night at entation of administration each m 03/01/23 to 03/31/23.				
	<ul> <li>Review of Resident #1's flowsheet for March 2023 revealed:</li> <li>There was documentation Resident #1's FSBS was checked three times each day at breakfast, lunch and dinner.</li> <li>There was documentation FSBS ranged from 136 to 227 at breakfast.</li> <li>There was documentation FSBS ranged from 71 to 294 at lunch.</li> <li>There was documentation FSBS ranged from 93 to 284 at dinner.</li> </ul>					
	Review of Resident #1's MAR for April 2023 revealed: -There was a computerized entry for Tresiba FlexTouch 38 units to be injected each night at bedtime. -There was documentation of administration each night at 8:00pm from 04/01/23 to 04/06/23 and from 04/12/23 to 04/30/23. -There was documentation Tresiba FlexTouch was not administered on 04/07/23 to 04/11/23 because he was on a home visit.					
Division of 4	revealed: -There was docume was checked three lunch and dinner. -There was docume 144 to 217 at break based on legibility of	#1's flowsheet for April 2023 entation Resident #1's FSBS times each day at breakfast, entation FSBS ranged from fast. (Range is approximate of documentation.) entation FSBS ranged from 84				

Division	of Health Service Re	equilation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		LETED
		FCL058008	B. WING		R 05/08/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FIELDS I	OUNDATION		D-FIELDS LA STON, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 330	Continued From pa	ge 27	C 330			
	legibility of documer -There was documer 121 to 371 at dinner based on legibility of Review of Resident revealed: -There was a comp	entation FSBS ranged from r. (Range is approximate				
	bedtime. -There was docume	entation of administration each n 05/01/23 to 05/07/23.				
	revealed: -There was docume was checked three lunch and dinner. -There was docume to 203 at breakfast. -There was docume 126 to 179 at lunch	entation FSBS ranged from entation FSBS ranged from				
	revealed: -He gave himself Tr system at night and went home for visits -One cap was remo- plastic tip was press administration. -he felt better since medication on 05/08 -His blood sugars ra 05/06/23 and has b	oved from the needle and the sed to his skin for staff began administering his				

Division	of Health Service Re	equiation			FURIN	APPROVE
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		FCL058008	B. WING			R 08/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		1057 LAI	ND-FIELDS LA	ANE .		
FIELDS	FOUNDATION	WILLIAM	STON, NC 27	7892		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 330	Continued From pa	ge 28	C 330			
		e interview with Resident #1's er (PCP) on 05/08/23 at cessful.				
		interview with the Registered facility on 05/05/23 at 4:05pm.				
		Refer to interview with the facility Manager on 05/08/23 at 4:45pm.				
		Refer to interview with the Assistant to the Administrator on 05/08/23 at 5:15pm.				
		v with the Registered Nurse on 05/05/23 at 4:05pm				
	-She remembered of the MAs individually	ble for educating facility staff. completing an in-service with y when the residents were nsulins to be administered via				
	the pen delivery system date.	stem, but she did not recall the				
	administering medi	uded the procedure for cations by injection and how to ial up the dose using the pen				
	-The in-service did needle for administ	not include uncapping the ration. e staff did not know about				
	removing the secor	ad cap to expose the needle tration of the medications.				
	4:45pm revealed:	acility Manager on 05/08/23 at s responsible for education				
	and trainings.	diabetic education yearly.				
	-The full procedure the needle should h	, including the uncapping of have been included in the				
ivision of H	lealth Service Regulation	tration of insulin using the pen				

STATEME	of Health Service Re NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		FCL058008	B. WING			R 05/08/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
FIELDS	FOUNDATION		ND-FIELDS LA ISTON, NC 27				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
C 330	Continued From pa	ge 29	C 330				
	medications proper ordered. -He was not sure ex- consisted of. -He did not know st needle for proper a medications. -It was important re medications as order them healthy. Interview with the A on 05/08/23 at 5:15 -The facility RN was MAs to ensure they medications comper- He expected each medications by pen uncapping, to be co The facility failed to to sampled insulin of caused high blood as the heart. High blood the Residents to de condition. The failur substantial risk for a and death and conservation. The facility provided accordance with G. this violation.	s responsible for training the were administering					

	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
			D. MILLO		R	
FCL		FCL058008	B. WING		05/	08/2023
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
FIELDS	FOUNDATION		ND-FIELDS LA ISTON, NC 27			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
C 342	Continued From pa	ge 30	C 342			
C 342	10A NCAC 13G .10 Administration	004(j) Medication	C 342			
	<ul> <li>(j) The resident's m record (MAR) shall following:</li> <li>(1) resident's name</li> <li>(2) name of the me</li> <li>(3) strength and do medication adminis</li> <li>(4) instructions for a or treatment;</li> <li>(5) reason or justific medications or treat documenting the re</li> <li>(6) date and time of</li> <li>(7) documentation of medications or treat omission, including</li> <li>(8) name or initials the medication or treat signature equivalent documented and m administration reconstruction</li> </ul>	dication or treatment order; osage or quantity of stered; administering the medication cation for the administration of tments as needed (PRN) and soluting effect on the resident; f administration; of any omission of tments and the reason for the refusals; and of the person administering reatment. If initials are used, a to those initials is to be taintained with the medication rd (MAR).				
	reviews, the facility medication adminis for 1 of 3 sampled r	failed to ensure the stration records were accurate residents (#3) who had severa red for a medication used to	I			
	The findings are:					
		ty's Medication Administration evealed medications should be	e			

RDWP11

If continuation sheet 31 of 52

STATEMEN	of Health Service Re NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		COM	E SURVEY PLETED
	FCL058008				05/	08/2023
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
FIELDS	FOUNDATION		ND-FIELDS LA ISTON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 342	Continued From pa	ge 31	C 342			
	administered in acc practitioner's orders	ordance with the prescribing				
	02/01/23 revealed: -Diagnoses include -There was no infor orientation status.	t #3's current FL-2 dated d diabetes type II. mation documented for er for diabetic testing 4 times				
	12/28/22 revealed h Review of Resident	#3's lab report dated her hemoglobin A1C was 8.2. #3's lab report for 03/31/23 globin A1C was 8.5.				
	2023 revealed: -There was docume fingerstick blood su times each day at b bedtime. -The FSBS ranged breakfast. -The FSBS ranged -The FSBS ranged dinner.	#3's flowsheet for February entation Resident #3's Igar (FSBS) was checked four preakfast, lunch, dinner and from 100 to 146 before from 123 to 269 before lunch. from 168 to 423 before from 150 to 344 at bedtime.				
	2023 revealed: -There was docume was checked four ti lunch, dinner and b -The FSBS ranged breakfast. -The FSBS ranged	#3's flowsheet for March entation Resident #3's FSBS imes each day at breakfast, edtime. from 106 to 194 before from 137 to 276 before lunch. from 144 to 366 before				

6899

RDWP11

If continuation sheet 32 of 52

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	- (X3) DATE SURVEY COMPLETED - R - 05/08/2023	
		FCL058008	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FIELDS I	FOUNDATION		D-FIELDS LA STON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
C 342	Continued From pa	age 32	C 342			
	-The FSBS ranged	from 125 to 359 at bedtime.				
	revealed: -There was docum was checked four t lunch, dinner and b -The FSBS ranged breakfast. -The FSBS ranged dinner. -The FSBS ranged Review of Residem revealed: -There was docum was checked four t lunch, dinner and b -The FSBS ranged breakfast. -The FSBS ranged -The FSBS ranged	from 106 to 194 before from 137 to 276 before lunch. from 144 to 366 before from 125 to 359 at bedtime. t #3's flowsheet for May 2023 entation Resident #3's FSBS imes each day at breakfast,				
	a. Review of Resid 02/01/23 revealed a Flexpen, 12 units to each day with lunch short-acting insulin levels.) Review of Residem 10/12/22 revealed	ent #3's current FL-2 dated a physician's order for Novolog o be administered by injection n and breakfast. (Novolog is a used to control blood sugar t #3's physicians order dated Novolog 10 units, to be				
iaian af Ll	each day. Review of Residen 12/28/22 revealed	ection with breakfast and lunch t #3's physicians order dated an order to increase Humalog akfast and lunch each day.				

Division	of Health Service Re	egulation				APPROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		FCL058008	B. WING			R 08/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
FIELDS	FOUNDATION		ND-FIELDS LA ISTON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 342	Continued From pa	ge 33	C 342			
	(Humalog is a shor blood sugar levels.)	t acting insulin used to control )				
	03/31/23 revealed: -Humalog 14 units injection with break -There was docume given depending or Review of Resident administration reco revealed: -There was a comp	rd (MAR) for March 2023 outerized entry for Novolog				
	breakfast and lunch -There was docume	be administered with n. entation of administration each 12:00pm from 03/01/23 to				
	revealed: -There was a comp Flexpen 12 units to breakfast and lunch -The 12 was marked handwritten above instructions to start -There was docume	ed through and 14 was the entry and handwritten				
	revealed: -There was a comp Flexpen 14 units to breakfast and lunch -There was docume units was administe	t #3's MAR for May 2023 buterized entry for Novolog be administered with n. entation Novolog Flexpen 14 ered each day at 8:00am on 13 and at 12:00pm on 05/01/23				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED	
		FCL058008	B. WING			R 05/08/2023	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
FIELDS	FOUNDATION		ND-FIELDS LA /ISTON, NC 27				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
C 342	Continued From pa	age 34	C 342				
	to 05/04/23.						
	Nurse (RN) for Res	interview with the Registered sident #3's primary care fice on 05/08/23 at 9:25am.					
	Refer to interview v 11:20am.	Refer to interview with the MA on 05/8/23 at 11:20am.					
	Refer to interview v at 1:25pm.	vith a second MA on 05/08/23					
	Refer to interview v 05/08/23 at 10:05a	vith the facility Manager on m.					
	Refer to interview v Administrator on 05	vith the Assistant to the 5/08/23 at 4:15pm.					
	02/01/23 revealed a Basaglar 40 units te	ent #3's current FL-2 dated a physician's order for o be administered each night glar is a long acting insulin od sugar levels.)					
	09/16/22 revealed	t #3's physicians order dated Lantus was to be increased to (Lantus is long-acting insulin od sugar levels.)					
		t #3's physicians order dated Lantus was to be increased to					
		t #3's physicians order dated Lantus was to be increased to					

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		FCL058008	B. WING		R 05/08/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
FIELDS F	OUNDATION		ND-FIELDS LA ISTON, NC 27			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET
C 342	Continued From pa	ige 35	C 342			
	revealed: -There was a comp units that was mark 40 over the units to -There was docume day at 5:00pm from Review of Resident revealed: -There was a comp units to be adminis -The 38 was marke 42 was also marke 46 handwritten ove -There was docume day at 5:00pm from Review of Resident revealed: -There was a comp with hand written 40 each day. -There was docume administered each 05/04/23. Attempted telephor primary care provid and 1:35pm and ag was unsuccessful.	ord (MAR) for March 2023 outerized entry for Basaglar 38 ked through with a hand written be administered with dinner. entation of administration each 0 03/01/23 to 03/31/23. t #3's MAR for April 2023 outerized entry for Basaglar 38				
	Nurse (RN) for Res provider's (PCP) of	interview with the Registered sident #3's primary care fice on 05/08/23 at 9:25am. vith the MA on 05/8/23 at				
	11:20am. ealth Service Regulation					

	of Health Service Re IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI F	CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
		FCL058008	B. WING			R 08/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
		1057 LAI	ND-FIELDS LA	NE			
FIELDS	FOUNDATION	WILLIAN	ISTON, NC 27	7892			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
C 342	Continued From pa	ge 36	C 342				
	Refer to interview w at 1:25pm.	vith a second MA on 05/08/23					
	Refer to interview with the facility Manager on 05/08/23 at 10:05am.						
	Refer to interview w Administrator on 05	vith the Assistant to the 5/08/23 at 4:15pm.					
	Telephone interview with the Registered Nurse (RN) for Resident #3's primary care provider's (PCP) office on 05/08/23 at 9:25am revealed: -Resident #3 was diagnosed with diabetes that was uncontrolled. -It was important for MARs to be accurate in						
	order to properly ac ordered. -Both Long and sho	Iminister medications as ort acting insulins had been imes in an effort to control the					
	blood vessels inclu	etes caused damage to small ding the heart and eyes. that were too low could lead					
	to dizziness, falls an -Blood sugar levels to diabetic ketoacid	nd possibly coma. that were too high could lead losis (DKA) due to the					
	become toxic, requ	o quickly and the body would iring hospitalization. run too low or too high could					
	05/08/23 at 11:20ar -Medication orders	should be clear and accurate					
	medication as orde	ure residents' received the red by the physician. gh dose changes when the					
		for a medication, but she did t the dates for the changes					

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED	
		FCL058008	B. WING			R 08/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FIFI DS F	FOUNDATION		ND-FIELDS LA			
		WILLIAM	ISTON, NC 27	/892		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
C 342	Continued From pa	nge 37	C 342			
	doses were given of the MARs. -She did not know s dose each time the -The facility RN cor she may have taug changing medication remember.	npleted her MA training and ht the process for correctly ons on the MAR but she did no				
	1:25pm revealed: -She had oversight duties included ens administered as or orders and medicat accurately. -Any new orders fo re-written in a blank documentation that should be made in documentation port medication.	tion beside the discontinued				
	prescribed insulins day by reviewing R -She was not award and overwriting the dose changed. -There was no proc MARs for accuracy	e the MA was marking through dose when the medication cess in place for reviewing				
	the MAR was taugh RN.	nanging medication orders on nt in MA training by the facility acility Manager on 05/08/23 at				
	-He expected MAR -He and the Assista	s to be clear and accurate. ant Administrator were wing MARs for accuracy but				

STATE FORM

ATEMENT OF DEFICIENCIES		(X2) MULTIPLE	CONSTRUCTION	(X3) DATI	E SURVEY
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLETED
	FCL058008	B. WING		R 05/08/2023	
ME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ELDS FOUNDATION		ID-FIELDS LA			
		STON, NC 27			
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 342 Continued From p	age 38	C 342			
March 2023 when of absence. -Staff were trained transcribe orders u -He was not aware doses instead of tr block as she was f -He thought the M save time because maybe that was ho facility she worked Interview with the A on 05/08/23 at 4:1 -MARs should be a administration of m clearly what was a -He usually review monthly but he had because of perso -He thought staff k to do it and were d The facility failed tr administration reco the dose of insulin a resident with und increased the risk associated with un The facility's failure medication admini to the health, safet and constitutes a The facility provide	a the MA had marked through anscribing the order in a new aught. A may have taken a short cut to e of added responsibilities or ow orders were done at another for. Assistant to the Administrator 5pm revealed: accurate for proper nedications and should reflect dministered. ed resident records and MARs d not in a couple of months nal concerns. new what they should do, how oing it correctly. De ensure medication ords were accurate related to that was to be administered to controlled diabetes which of life-threatening conditions controlled blood sugar levels. to ensure the accuracy of the stration record was detrimental by and welfare of the resident				
THE CORRECTIO	N DATE FOR THE TYPE B				

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		FCL058008	B. WING		R 05/08/2023	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
FIELDS I	FOUNDATION		ND-FIELDS LA ISTON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 342	Continued From pa	ge 39	C 342			
	VIOLATION SHALL 2023.	NOT EXCEED JUNE 22,				
C 350	10A NCAC 13G .10 Self-Administration		C 350			
	Medications (a) The facility shall competent and phy their medications if met: (1) the self-adminis physician or other p prescribe medication documented in the (2) specific instruct prescription medication medication label. (b) The facility shall (1) there is a chang physical ability to se (2) the resident is r physician's orders; (3) the resident is r medication policies	non-compliant with the or non-compliant with the facility's and procedures. refuse medications does not f the resident to				
	facility failed to ensu physician's order wa residents (#1, #2, #	et as evidenced by: and record reviews, the ure an assessment and as in place for 3 of 3 sampled 3) who self-administered o control blood sugar by				

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		FCL058008	B. WING			R 08/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
FIELDS I	FOUNDATION		ND-FIELDS LA STON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 350	Continued From pa	ge 40	C 350			
	injection (#1, #2, #3	3).				
	The findings are:					
	dated) revealed: -The Resident wou able to self-adminis -There would be a self-adminis physician or other le prescribe. -The order would be 1. Review of Resided 02/01/23 revealed: -Diagnoses include -There was no infor orientation status. Review of Resident revealed an admiss Review of Resident care plan dated 07/ -Resident #3 requir staff for injections for	of Medication policy (not ld be competent and physically ster medications. self-administration order by a egally authorized person to e kept in the resident's record. ent #3's current FL-2 dated d diabetes type II. rmation documented for t #3's Resident Register sion date of 04/01/19.				
		#3's Licensed Health ort (LHPS) dated 04/03/23				
	(RN) for the facility.					
	"blood glucose 300 medications".	entation Resident #3 had on insulin and oral glycemic				
		ed blood glucose monitoring. umentation for LHPS task of				

Division of Health Service Regulation STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL058008		CONSTRUCTION	(X3) DATE SURVE COMPLETED R 05/08/202	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	03/	00/2023
FIELDS	FOUNDATION	1057 LA	ND-FIELDS LA ISTON, NC 27	NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
C 350	Continued From pa	ge 41	C 350			
	administering medi	cations by injection.				
	Review of Resident #3's resident record revealed there was no documentation of a physician's order for self-administration of any medication.					
	a. Review of Resident #3's current FL-2 dated 02/01/23 revealed a physician's order for Novolog Flexpen, 12 units to be administered by injection each day with lunch and breakfast.		3			
	Review of Resident #3's physicians order dated 10/12/22 revealed Novolog 10 units, to be administered by injection with breakfast and lunch each day.		n			
	12/28/22 revealed a to 12 units with brea	t #3's physicians order dated an order to increase Humalog akfast and lunch each day. acting insulin used to control )				
	03/31/23 revealed: -Humalog 14 units v injection with break -There was docume	t #3's physicians order dated were to be administered by fast and lunch each day. entation that Novolog could be n insurance coverage.				
	revealed:	rd (MAR) for March 2023				
	Flexpen 12 units to breakfast and lunch -There was docume	entation of administration each	n l			
	day at 8:00am and 03/31/23.	12:00pm from 03/01/23 to				
	Review of Resident	#3's MAR for April 2023				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED R
		FCL058008	B. WING		05/08/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
FIELDS I	FOUNDATION		ND-FIELDS LA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 350	Continued From pa	ige 42	C 350			
	Flexpen 12 units to breakfast and lunch -The 12 was marke handwritten above instructions to start -There was docume	ed through and 14 was the entry with handwritten				
	revealed: -There was a comp Flexpen 14 units to breakfast and lunch -There was docume units was administer	t #3's MAR for May 2023 buterized entry for Novolog be administered with n. entation Novolog Flexpen 14 ered each day at 8:00am on 23 and at 12:00pm on 05/01/23				
	02/01/23 revealed a	ent #3's current FL-2 dated a physician's order for Novolog b be administered each day				
	10/12/22 revealed I	t #3's physicians order dated Novolog Flexpen 12 units was by injection with dinner.				
		t #3's physicians order dated an order to increase Humalog ner.				
	03/31/23 revealed I	t #3's physicians order dated Humalog 16 units was to be ection each evening with				
	Review of Resident	t #3's medication				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		FCL058008	B. WING	B. WING		R 08/2023
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FIELDS	FOUNDATION		ND-FIELDS LA ISTON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 350	Continued From pa	ge 43	C 350			
	administration recorrevealed: -There was a comp Flexpen 14 units to -There was docume day at 5:00pm from Review of Resident revealed: -There was a comp Flexpen 14 units to -The 14 was marke handwritten above to instructions to start -There was docume day at 5:00pm from Review of Resident revealed: -There was a comp Flexpen 14 units to -There was docume units was administe 05/01/23 to 05/04/2 c. Review of Resident at bed time. (Basag used to control block Review of Resident 09/16/22 revealed L	rd (MAR) for March 2023 uterized enter for Novolog be administered with dinner. entation of administration each 03/01/23 to 03/31/23. #3's MAR for April 2023 uterized entry for Novolog be administered with dinner. d through and 16 was the entry with handwritten 03/31/23. entation of administration each 04/01/23 to 04/30/23. #3's MAR for May 2023 uterized entry for Novolog be administered with dinner. entation Novolog Flexpen 14 ered each day at 5:00pm on 3. ent #3's current FL-2 dated a physician's order for o be administered each night lar is a long-acting insulin				
		od sugar levels.) #3's physicians order dated _antus was to be increased to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		FCL058008	B. WING		R 05/08/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
FIELDS I	FOUNDATION		ND-FIELDS LA ISTON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
C 350	Continued From pa	ge 44	C 350			
		t #3's physicians order dated _antus was to be increased to				
	Review of Resident #3's physicians order dated 03/31/23 revealed Lantus 46 units was to be administered each day.					
	revealed: -There was a comp units that was mark 40 over the units to -There was docume	t #3's medication rd (MAR) for March 2023 outerized entry for Basaglar 38 ted through with a hand writter be administered with dinner. entation of administration each 0 03/01/23 to 03/31/23.				
	revealed: -There was a comp units to be administ scheduled for 8:00p -The 38 was marked 42 was also marked 46 handwritten over -There was docume	t #3's MAR for April 2023 puterized entry for Basaglar 38 tered every day and was om ed through, and a hand written d through with a hand written r the units to be administered. entation of administration each o 04/01/23 to 04/30/23.				
	revealed: -There was a comp with hand written 46 each day. -There was docume	t #3's MAR for May 2023 outerized entry for Basaglar 6 units to be administered entation Basaglar 46 units was day at 8:00pm on 05/01/23 to				
vision of H	revealed:	dent #3 on 05/08/23 at 1:12pm n daily; usually over 200.				

STATE FORM

RDWP11

If continuation sheet 45 of 52

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _		R	
		FCL058008	B. WING	05/08/2023		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FIELDS I	OUNDATION		ND-FIELDS LA /ISTON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
C 350	Continued From pa	ge 45	C 350			
	sometimes the staf -Her insulins were in the staff would dial medication before in herself. -She did not know in covering the needle removed the small medication before in Interview with the S (SIC)/medication an 1:56pm revealed: -Resident #3 usual and Lantus to herse administer the inject -She did not know in Resident #3 to be a injection.	in a pen delivery system and in the dose for each giving she gave the injection to there was a second cap a and she nor the staff cap prior to injecting the D5/05/23. Supervisor in Charge ide (MA) on 05/05/23 at ly administered her Humalog elf but sometimes staff would ctions. f there was an order for able to self administer the me interview with Resident #3's				
	9:16am was unsuc Refer to interview v (SIC)/medication a 1:56pm.	vith the Supervisor in Charge ide (MA) on 05/05/23 at				
		interview with the facility's cy on 05/08/23 at 2:15pm.				
	Refer to interview v 05/08/23 at 4:45pm	vith the facility Manager on n.				
	Refer to interview v Administrator on 05	vith the Assistant to the 5/08/23 at 5:15pm.				
	2. Review of Reside 06/30/22 revealed:	ent #1's current FL-2 dated				

STATEME	of Health Service Re NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL058008			05/	08/2023
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S <sup>-</sup> ND-FIELDS LA			
FIELDS	FOUNDATION		ISTON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 350	Continued From pa	ige 46	C 350			
C 350	disoriented. -There was an order checks three times -There was an order units to be administ bedtime. Review of Resident revealed he was account Review of Resident care plan date 07/1 -Resident #1 requires staff for eating and -Resident #1 requires staff for grooming.	entation he was intermittently er for fingerstick blood sugar each day. er for Tresiba FlexTouch 38 tered by injection each day at t #1's Resident Register dmitted on 06/05/08. t #1's current assessment and 5/22 revealed: red limited assistance from dressing. red extensive assistance from btally dependant on staff				
	Review of Resident there was no physic self-administration					
	revealed: -There was a comp FlexTouch 38 units bedtime. -There was docume	rd (MAR) for March 2023 outerized entry for Tresiba to be injected each night at entation of administration each	n			
<i>v</i> ision of H	Review of Resident revealed: -There was a comp FlexTouch 38 units bedtime.	m 03/01/23 to 03/31/23. t #1's MAR for April 2023 puterized entry for Tresiba to be injected each night at entation of administration each	n			

STATEMEN	of Health Service Re TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL058008	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	СОМ	E SURVEY PLETED R
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	05/	05/08/2023	
			ND-FIELDS LA			
FIELDS	FOUNDATION	WILLIAM	ISTON, NC 27	892		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 350	Continued From pa	ge 47	C 350			
	from 04/12/23 to 04 -There was docume	m 04/01/23 to 04/06/23 and I/30/23. entation Tresiba FlexTouch ed on 04/07/23 to 04/11/23				
	because he was on a home visit.					
	Review of Resident #1's MAR for May 2023 revealed: -There was a computerized entry for Tresiba FlexTouch 38 units to be injected each night at bedtime.					
	-There was documentation of administration each night at 8:00pm from 05/01/23 to 05/07/23.					
	revealed: -He gave himself T system at night and it when he went hor	dent #1 on 05/08/23 at 6:34pm resiba using the pen delivery I his family member would give me for visits. oved from the needle and the				
	plastic tip was pres administration. -He felt better since medication on 05/0	sed to his skin for e staff began administering his 5/23.				
	05/06/23 and has b	an in the 200s prior to een running in the 100s since ninistering the Tresiba.				
	(SIC)/medication ai 1:56pm revealed:	Supervisor in Charge de (MA) on 05/05/23 at himself his Tresiba injection				
	each night and had since before he wa -She did not know i	been giving himself injections s admitted to the facility. f there was an order for able to self administer the				
		ne interview with Resident #1's er (PCP) on 05/08/23 at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL058008		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		FCL058008				R 05/08/2023
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IELDS	FOUNDATION		ND-FIELDS LA /ISTON, NC 27			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
C 350	Continued From pa	ge 48	C 350			
	9:16am was unsuccessful.					
	Refer to interview with the Supervisor in Charge (SIC)/medication aide (MA) on 05/05/23 at 1:56pm.					
	Refer to telephone interview with the facility's contracted pharmacy on 05/08/23 at 2:15pm.					
	Refer to interview with the facility Manager on 05/08/23 at 4:45pm.					
	Refer to interview w Administrator on 05	vith the Assistant to the 5/08/23 at 5:15pm.				
	12/15/22 revealed: -Diagnoses include bipolar disorder and	er for Trulicity 1.5/0.5ml,1				
	revealed:	#2's Resident Register dmitted on 11/18/21.				
		glasses due to limited vision.				
		an's order dated 04/26/23 ng/0.5ml, 1 syringe was to be nesday.				
	there was no docur	#2's resident record revealed nentation of a physician's nistration of any medication.				
	revealed:	: #2's medication rd (MAR) for March 2023 outerized entry for Trulicity				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
	FCL058008	B. WING			R <b>08/2023</b>	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
		-				
		ISTON, NC 27				
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
Continued From page 49		C 350				
<ul> <li>Wednesday.</li> <li>There was documentation of administration on 03/01/23, 03/08/23, 03/15/23 and on 03/29/23.</li> <li>There was no documentation of administration on 03/22/23.</li> <li>Review of Resident #2's medication administration record (MAR) for April 2023 revealed:</li> <li>There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every Wednesday.</li> <li>There was documentation of administration on 04/05/23, 04/12/23, 04/19/23 and 04/26/23.</li> </ul>						
administration reco revealed: -There was a comp 3mg/0.5ml, 1 syring Wednesday.	rd (MAR) for May 2023 uterized entry for Trulicity je was to be injected every					
revealed: -She gave herself that came in a sing -She was taught by	he weekly injection of Trulicity le use pen. her primary care provider how					
(SIC)/medication ai 1:56pm revealed: -Resident #2 alway injection each week dose. -Resident #2 was ta	de (MA) on 05/05/23 at s gave herself the Trulicity c and the pens were single aught how to give the injection					
	OF CORRECTION PROVIDER OR SUPPLIER <b>FOUNDATION</b> SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From pa Wednesday. -There was docume 03/01/23, 03/08/23, -There was docume 03/01/23, 03/08/23, -There was no doct on 03/22/23. Review of Resident administration reco revealed: -There was a comp 3mg/0.5ml, 1 syring Wednesday. -There was docume 04/05/23, 04/12/23, Review of Resident administration reco revealed: -There was a comp 3mg/0.5ml, 1 syring Wednesday. -There was a comp 3mg/0.5ml, 1 syring Wednesday. -There was a comp 3mg/0.5ml, 1 syring Wednesday. -There was docume 05/03/23. Interview with Resident that came in a singl -She gave herself th that came in a singl -She was taught by to administer the m Interview with the S (SIC)/medication ai 1:56pm revealed: -Resident #2 always injection each week dose. -Resident #2 was ta at the doctor's office	OF CORRECTION       IDENTIFICATION NUMBER:         FCL058008       FCL058008         PROVIDER OR SUPPLIER       STREET A         FOUNDATION       1057 LAI         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       SUMMARY STATEMENT OF DEFICIENCIES         Continued From page 49       Wednesday.       -There was documentation of administration on 03/01/23, 03/08/23, 03/15/23 and on 03/29/23.         -There was no documentation of administration on 03/22/23.       Review of Resident #2's medication administration record (MAR) for April 2023 revealed:         -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every Wednesday.       -There was documentation of administration on 04/05/23, 04/12/23, 04/19/23 and 04/26/23.         Review of Resident #2's medication administration record (MAR) for May 2023 revealed:       -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every Wednesday.         -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every Wednesday.       -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every Wednesday.         -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every Wednesday.       -There was documentation of administration on 05/03/23.         Interview with Resident #2 on 05/05/23 at 6:05pm revealed: -She was taught by her primary care provider how to administer the medication by injection.         <	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         FCL058008       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST         SUMMARY STATEMENT OF DEFICIENCIES LAWILLIAMSTON, NC 27         VECONDATION       1057 LAND-FIELDS LAWILLIAMSTON, NC 27         SUMMARY STATEMENT OF DEFICIENCIES       ID         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         TAG       C 350         Wednesday.	OF CORRECTION     DENTIFICATION NUMBER:     A. BUILDING:       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       SOUNDATION     1057 LAND.FIELDS LANE WILLIAMSTON, NC 27892       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BO YPULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BO YPULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D PREFIX TAG     PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BO YPULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D PREFIX TAG     PROVIDER'S PLAN OF (EACH ORRECTIVE AC (CROSS-REFERENCED TO DEFICIENT VECHCORRECTIVE AC (CROSS-REFERENCED TO DEFICIENT       Continued From page 49     C 350     C 350       Wednesday.     -There was no documentation of administration on 03/22/23.     C 350       Review of Resident #2's medication administration record (MAR) for April 2023 revealed:     -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every Wednesday.       -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every Wednesday.     -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every Wednesday.       -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every Wednesday.	OF CORRECTION       DENTIFICATION NUMBER:       A BUILDING:       05/         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       05/         COUNDATION       1057 LAND-FIELDS LANE       05/         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTIVE ACTION SOLUD BE         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       ID       PREFIX       CASS-REFERENCED TO THE APPROPRIATE DEFICIENCES         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       TAG       DEPREFIX       CASS-REFERENCED TO THE APPROPRIATE DEFICIENCES         (EACH DEFICIENCY OR USC DENTIFINGS INFORMATION)       TAG       DEPREFIX       CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY         Continued From page 49       C 350       C 350       CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY         Wednesday.       -There was no documentation of administration on 03/22/23.       C 350       CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY         There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every       Wednesday.       -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every       Wednesday.         -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every       Wednesday.       -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every         Wednesday.       -There was a computerized entry fo	

Division of Health Service Regulation         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 05/08/2023		
	FCL058008				05/	08/2023
	PROVIDER OR SUPPLIER		DRESS, CITY, ST D-FIELDS LA			
FIELDS	FOUNDATION		STON, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
C 350	Continued From page 50		C 350			
	Resident #2 to be able to self administer the injection.					
	Attempted telephone interview with Resident #2's primary care provider (PCP) on 05/08/23 at 9:16am was unsuccessful.					
	Refer to interview with the Supervisor in Charge (SIC)/medication aide (MA) on 05/05/23 at 1:56pm.					
	Refer to telephone interview with the facility's contracted pharmacy on 05/08/23 at 2:15pm.					
	Refer to interview with the facility Manager on 05/08/23 at 4:45pm.					
	Refer to interview w Administrator on 05	ith the Assistant to the /08/23 at 5:15pm.				
	(SIC)/medication aid 1:56pm revealed:	upervisor in Charge de (MA) on 05/05/23 at self-administered by the				
	-She was not aware	e residents needed to have a place to self-administer				
	pharmacy on 05/08 -Residents should b	with the facility's contracted /23 at 2:15pm revealed: be assessed to ensure they to self-administering				
	-Without ensuring a self-administering n not receive the corr	resident was capable of nedications, the resident may ect dose or, if administered by se infection if not given				

Division of Health Service Regulation           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R	
		FCL058008	B. WING			08/2023
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IELDS	FOUNDATION		ND-FIELDS LA ISTON, NC 27			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
C 350	Continued From page 51		C 350			
	4:45pm revealed: -He thought self-ad place for the reside -He thought the reside taught them how to themselves. -He thought the reside administering their MA dialed up the de Interview with the A on 05/08/23 at 5:15 -He did not know si for self administrati -The prescriber wo assessing whether administer medicat -He thought the self	sidents' prescribing physician o give the injections to sidents were capable of insulins by injection after the ose. Assistant to the Administrator 5pm revealed: taff were not aware an order ion was required. build be responsible for r a resident was able to self tions prior to writing the order. If-administration orders were in lents that self-administered				