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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDS FOUNDATION	1057 LAND-FIELDS LANE WILLIAMSTON, NC 27892

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Martin County Department of Social Services completed an annual and follow up survey on 05/05/23 and 05/08/23.	C 000		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure fire safety equipment was maintained in a safe operating condition related to a smoke detector that was not functioning properly due to a dead battery. The findings are: Review of the facility's Fire Safety Policy (not dated) revealed: -The facility would maintain the fire safety equipment in a safe and operating condition. -If the fire equipment becomes inoperative, the facility would call the proper maintenance personnel to repair equipment as soon as possible. -The facility would schedule additional staff for	C 102		

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C 102	Continued From page 1	C 102		

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 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

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C 102	Continued From page 2 4:45pm revealed: -It was important to keep equipment functioning properly in-case of a fire. -He did not remember hearing the smoke detector beeping when he visited the facility on 05/05/23 and he thought the beeping had just begun on 05/05/23. -He was contacted on 05/05/23 in the early afternoon about the smoke alarm beeping. -Smoke detector batteries were checked yearly during the annual fire inspection but the facility used batteries that were suppose to be good for 10 years. -He expected staff to review facility policies, including fire safety yearly and report any smoke detectors where suspected of not working properly immediately. Interview with the Assistant to the Administrator on 05/08/23 at 4:50pm revealed: -He contacted an electrician to come and check the smoke detector for proper functioning on 05/05/23 immediately after being notified of the beeping. -He had not noticed the smoke detector was beeping and not operating as it should. Observation of the facility on 05/05/23 at 5:46pm: -Two men entered the facility with a ladder and were directed to the resident room with the beeping smoke detector. -The battery was changed in the smoke detector. -The smoke detector no longer beeped. _____ The facility failed to ensure safety equipment was maintained in safe operating condition as evidenced by a beeping smoke detector that was ignored by staff that was present. The facility's failure to ensure the safe operating condition of safety equipment was detrimental to the health,	C 102		

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C 102	Continued From page 3 safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/05/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 22, 2023.	C 102		
C 132	10A NCAC 13G. 0403(b) Qualifications Of Medication Staff (b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure staff administering medications had the required 6 hours of annual training for medication administration. The findings are: 1. Review of Staff A's personnel record revealed: -She was hired on 03/12/21 as a medication aide (MA).	C 132		

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C 132	Continued From page 4 -She completed 15 hour medication aide training on 05/21/21. -The was documentation she passed the Medication Aide exam on 06/02/21. -She completed the Medication Administration Clinical Skills Checklist on 05/18/21. -There was documentation of 1 hour of continuing education related to medication administration conducted on 03/30/22 by a local geriatric/adult mental health specialty team. Review of a resident's medication administration record for April 2023 revealed Staff A administered medications 18 of 31 days. Interview with Staff A on 05/08/23 at 11:20am revealed : -She received medication training once in awhile but could not remember when she last received medication training. -She did not think she received 6 hours of medication training each year. -She did not know 6 hours of continuing education for medication was required each year. 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. 2. Review of Staff B's personnel record revealed: -She was hired on 01/06/06 as a MA. -The was documentation she passed the Medication Aide exam on 09/13/07. -She completed the Medication Administration Clinical Skills Checklist on 10/01/07. -There was documentation of 1 hour of continuing education related to medication administration conducted on 03/30/22 by a local geriatric/adult	C 132		

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mental health specialty team.
-There was documentation of a 3 hour training on nebulization and inhalers on 04/20/22.

Review of a resident's medication administration record for April 2023 revealed Staff A administered medications 12 of 31 days.

Interview with Staff B on 05/08/23 at 1:25pm revealed:
-She supervised the other MAs in the facility.
-She was not aware she needed to have 6 hours of medication and 6 hours of management continuing education each year.
-She could not remember the last time she received continuing education for medications.
-She had not received continuing education for management.

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.

3. Review of Staff C's personnel record revealed:
-She was hired on 07/21/19 as a MA.
-She completed 15 hours of medication aide training on 07/12/19.
-There was documentation he passed the Medication Aide exam on 08/05/19.
-She completed the Medication Administration Clinical Skills Checklist on 07/12/19.
-There was documentation of 1 hour of continuing education related to medication administration conducted on 03/30/22 by a local geriatric/adult mental health specialty team.

Review of a resident's medication administration record for April 2023 revealed Staff C

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C 132	Continued From page 6 administered medications 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. _____ Interview with the Facility Manager on 05/08/23 at 4:00pm revealed: -He was responsible for scheduling trainings for the staff. -He thought MAs were required to have 12 hours of continuing education each year. -He used to schedule trainings with a local mental health team but the team had become unreliable over the past year. -He thought there had been more trainings but he did not know when they happened. Interview with the Assistant to the Administrator on 05/08/23 at 5:15pm revealed: -The Administrator and the facility Manager were responsible for scheduling trainings for the staff. -He did not know when trainings were conducted. Refer to Tag 330 10A NCAC 13G .1004(a) Medication Administration. Refer to Tag 330 10A NCAC 13G .1004(j) Medication Administration. _____ The facility failed to ensure medication aides received 6 hours of continuing education credits each year for medication aides that administered medications including high risk medication such as insulin by injection. The facility's failure to ensure 6 hours of continuing education was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation.	C 132		

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C 132	Continued From page 7 The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/08/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 22, 2023.	C 132		
C 134	10A NCAC 13G .0402 Qualifications of Supervisor-In-Charge 10A NCAC 13G .0402 Qualifications of Supervisor-In-Charge The supervisor-in-charge, who is responsible to the administrator for carrying out the program in a family care home in the absence of the administrator, shall meet the following requirements: (1) be 21 years or older, if employed on or after the effective date of this Rule; (2) the supervisor-in-charge, employed on or after August 1, 1991, shall be a high school graduate or certified under the GED Program or passed the alternative examination established by the Department of Health and Human Services prior to the effective date of this Rule; and (3) earn 12 hours a year of continuing education credits related to the management of adult care homes and care of aged and disabled persons. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION	C 134		

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C 134	Continued From page 8 Based on interviews and record reviews, the facility failed to ensure the Supervisor in Charge received 12 hours of continuing education related to management of adult care homes and care of the aged and disabled persons. The findings are: Review of Staff B's personnel record revealed: -She was hired on 01/06/06 as a medication aide (MA). -She completed the Medication Administration Clinical Skills Checklist on 10/01/07. -There was documentation of 1 hour of continuing education related to medication administration conducted on 03/30/22 by a local geriatric/adult mental health specialty team. -There was documentation of a 3 hour training on nebulization and inhalers on 04/20/22. -There was documentation of a 1 hour Team Building education on 09/28/22. Interview with Staff B on 05/08/23 at 1:25pm revealed: -She supervised the other MAs in the facility. -It was her responsibility to ensure medication orders were implemented, medications were administered as ordered, and residents' attended their scheduled appointments. -Staff concerns were reported to her and she would notify the facility Manager or the Assistant to the Administrator since the Administrator was not available due to a medical concern. -She was not aware she needed to have 12 hours of continuing education each year. -She had not received continuing education specific to the management of adult care homes. Interview with the Facility Manager on 05/08/23 at 4:00pm revealed:	C 134		

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C 134	Continued From page 9 -He was responsible for scheduling trainings for the staff. -He thought MAs were required to have 12 hours of continuing education each year but he did not know 6 hours in management were required for the Supervisor in Charge. -He thought there had been more trainings but he did not know when they happened. Interview with the Assistant to the Administrator on 05/08/23 at 5:15pm revealed: -The Administrator and the facility Manager were responsible for scheduling trainings for the staff. -He was not aware 6 hours in management were required for the Supervisor in Charge. -He did not know when trainings were conducted. _____ The facility failed to ensure medication aides received 6 hours of continuing education credits each year for medication aides that administered medications including high risk medication such as insulin by injection. The facility's failure to ensure 6 hours of continuing education was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/08/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 22, 2023.	C 134		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff	C 185		

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C 185	Continued From page 10 (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the Administrator failed to ensure the total operation of the facility to meet the rule areas related to building service equipment, medication administration, qualifications of supervisor in charge and qualifications of medication staff. The findings are: Review of the facility's license revealed: -The facility was licensed effective 01/01/23 for a capacity of 6 ambulatory residents. -The expiration date of the facility's license was 12/31/23. Observation of the facility upon arrival on 05/05/23 at 8:30am revealed: -Six residents were at the facility. -The medication aide (MA) was present. -The Administrator was not on-site.	C 185		

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C 185	Continued From page 11 Interview with a MA on 05/08/23 at 11:20am revealed: -The SIC was the Supervisor in Charge (SIC) and she reported any issues to her. -The Administrator had been on a leave of absence but she could not say how long. Interview with the SIC on 05/08/23 at 1:25pm revealed: -She was the Supervisor in Charge for the MAs at the facility. -Staff concerns were reported to her and she would notify the facility Manager or the Assistant to the Administrator since the Administrator was not available. -She was not aware of any process for oversight of her work role but the facility had monthly staff meetings to discuss concerns that came up. Interview with the facility Manager on 05/08/23 at 10:05am revealed: -The Administrator was in the facility at least weekly prior to March 2023. -He and the Assistant to the Administrator took on the duties of the Administrator temporarily since she had been out. -Staff would call him first but could always call the Assistant to the Administrator if he was not available. -He expected the Administrator to return at the end on May 2023. -They had not looked for a temporary Administrator since the Administrator was going to return to duties within a few months of being absent. Interview with the Assistant to the Administrator on 05/08/23 at 5:15pm revealed: -The Administrator had been on a leave of	C 185		

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absence since March 2023.
-He and the facility Manager were managing the facility temporarily until the Administrator was able to return.
-He lived next door to the facility and was in and out of the facility almost daily.
-He and the facility Manager were always available by phone for staff questions or issues that came up.
-He had "good staff" and he thought they were doing what was required in the facility.
-Oversight of staff had not been what it should have since the Administrator went out in March 2023 and things had fallen through the cracks.

Non-compliance was identified in the following rule areas:

1. Based on observations and interviews, the facility failed to ensure fire safety equipment was maintained in a safe operating condition related to a smoke detector that was not functioning properly due to a dead battery. [Refer to Tag 102 10A NCAC 13G .0317(a) Building Service Equipment (TYPE B VIOLATION)].

2. Based on interviews and record reviews, the facility failed to ensure staff administering medications had thr required 6 hours of annual training for medication administration. [Refer to Tag 132 10A NCAC 13G .0403(b) Qualifications of Medication Staff (TYPE B VIOLATION)].

3. Based on interviews and record reviews, the facility failed to ensure the staff supervisor for staff that were administering medications had the required 6 hours of continuing education for management annually. [Refer to Tag 134 10A NCAC 13G .0402 Qualifications of Supervisor-in-Charge (TYPE B VIOLATION)].

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C 185	Continued From page 13 4. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents (#1, #3) that were prescribed long-acting insulin (#1, #3) and a short acting insulin (#3) to be administered by injection. [Refer to Tag 330 10A NCAC 13G .1004(a) Medication Administration (TYPE B VIOLATION)]. 5. Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#3) who had several dose changes ordered for a medication used to control blood sugar. [Refer to Tag 342 10A NCAC 13G .1004(j) Medication Administration (TYPE B VIOLATION)]. 6. Based on interview and record reviews, the facility failed to ensure an assessment and physician's order was in place for 3 of 3 sampled residents (#1, #2, #3) who self-administered medications used to control blood sugar by injection (#1, #2, #3). [Refer to Tag 350 10A NCAC 13G .1005 Self-Administration of Medications (Standard Deficiency)]. _____ The Administrator failed to ensure the overall management and total operations of the facility as evidenced by failure to maintain substantial compliance with the rules and statutes governing Adult Care Homes, related to building service equipment, medication administration, qualifications of supervisor in charge and qualifications of medication staff. This failure detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in	C 185		

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C 185	Continued From page 14 accordance with G.S. 131D-34 on 05/08/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 22, 2023.	C 185		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents that were prescribed long-acting insulin (#1, #3) and a short acting insulin (#3) to be administered by injection. The findings are: Review of the facility's Medication Administration Policy (not dated) revealed: -Medications should be administered in accordance with the prescribing practitioner's orders. -Staff who have demonstrated competency	C 330		

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C 330	Continued From page 15 according to State rules may prepare and administer medications. 1. Review of Resident #3's current FL-2 dated 02/01/23 revealed: -Diagnoses included diabetes type II. -There was no information documented for orientation status. Review of Resident #3's Resident Register revealed an admission date of 04/01/19. Review of Resident #3's Licensed Health Professional Support (LHPS) dated 04/03/23 revealed: -The LHPS was signed by the facility's Registered Nurse (RN). -There was documentation Resident had "blood glucose 300 on insulin and oral glycemic medications". -LHPS tasks included blood glucose monitoring. -There was no documentation for LHPS task of administering medications by injection. Observation of Novolog administration on 05/05/23 at 11:56am revealed: (Novolog is a short acting insulin used to control blood sugar levels.) -The medication aide (MA) put a new needle on the Novolog pen and dialed up 14 units before she placed a NovoLog pen in front of Resident #3. -Resident #3 requested assistance to administer the injection. -The MA washed her hands and donned gloves before picking up the Novolog pen. -The MA removed 1 cap to reveal a smaller cap that covered the needle. -The MA placed the capped needle to Resident #3's abdomen and pressed the pen to administer	C 330		

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the medication.
-The MA removed and discarded the capped needle into a biohazard container.

Interview with the MA on 05/05/23 at 11:53am revealed:
-She thought the Novolog pen was a new way of administering the insulin and the insulin was administered through the small cap covering the needle.
-She did not know the second cap covering the needle needed to be removed prior to administration of the medication.
-Resident #3's Novolog and Lantus insulins were in the same type pen delivery system and used the same type needles.
-Both insulins were administered the same way without removing the small cap that covered the needle.
-She thought the small cap remained in place during administration for safety and so the injection did not hurt as bad.

Review of Resident #3's lab report dated 12/28/22 revealed her hemoglobin A1C was 8.2. (According to the American Diabetes Association, a hemoglobin A1C value of 5.7 to 6.4 is prediabetes and a value of 6.5 and above is in the diabetic range. The goal range for people living with diabetes is less than 7.)

Review of Resident #3's lab report for 03/31/23 revealed her hemoglobin A1C was 8.5.

Review of Resident #3's flowsheet for February 2023 revealed:
-There was documentation Resident #3's fingerstick blood sugar (FSBS) was checked four times each day at breakfast, lunch, dinner and bedtime.

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C 330	Continued From page 17 -The FSBS ranged from 100 to 146 before breakfast. -The FSBS ranged from 123 to 269 before lunch. -The FSBS ranged from 168 to 423 before dinner. -The FSBS ranged from 150 to 344 at bedtime. Review of Resident #3's flowsheet for March 2023 revealed: -There was documentation Resident #3's FSBS was checked four times each day at breakfast, lunch, dinner and bedtime. -The FSBS ranged from 106 to 194 before breakfast. -The FSBS ranged from 137 to 276 before lunch. -The FSBS ranged from 144 to 366 before dinner. -The FSBS ranged from 125 to 359 at bedtime. Review of Resident #3's flowsheet for April 2023 revealed: -There was documentation Resident #3's FSBS was checked four times each day at breakfast, lunch, dinner and bedtime. -The FSBS ranged from 106 to 194 before breakfast. -The FSBS ranged from 137 to 276 before lunch. -The FSBS ranged from 144 to 366 before dinner. -The FSBS ranged from 125 to 359 at bedtime. Review of Resident #3's flowsheet for May 2023 revealed: -There was documentation Resident #3's FSBS was checked four times each day at breakfast, lunch, dinner and bedtime. -The FSBS ranged from 80 to 172 before breakfast. -The FSBS ranged from 50 to 225 before lunch. -The FSBS ranged from 113 to 331 before dinner.	C 330		

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C 330	Continued From page 18 -The FSBS ranged from 103 to 314 at bedtime. 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. 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. Review of Resident #3's physicians order dated 12/28/22 revealed an order to increase Humalog to 12 units with breakfast and lunch each day. (Humalog is short-acting insulin used to control blood sugar levels.) Review of Resident #3's physicians order dated 03/31/23 revealed: -Humalog 14 units were to be administered by injection with breakfast and lunch each day. -There was documentation that Novolog could be given depending on insurance coverage. Review of Resident #3's medication administration record (MAR) for March 2023 revealed: -There was a computerized entry for Novolog Flexpen 12 units to be administered with breakfast and lunch. -There was documentation of administration each day at 8:00am and 12:00pm from 03/01/23 to 03/31/23. Review of Resident #3's MAR for April 2023 revealed: -There was a computerized entry for Novolog Flexpen 12 units to be administered with breakfast and lunch.	C 330		

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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 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 Assistant to the Administrator on 05/08/23 at 5:15pm. 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. Review of Resident #3's physicians order dated	C 330		

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03/31/23 revealed Humalog 16 units was to be administered by injection each evening with dinner.

Review of Resident #3's medication administration record (MAR) for March 2023 revealed:
-There was a computerized enter for Novolog Flexpen 14 units to be administered with dinner.
-There was documentation of administration each day at 5:00pm from 03/01/23 to 03/31/23.

Review of Resident #3's MAR for April 2023 revealed:
-There was a computerized entry for Novolog Flexpen 14 units to be administered with dinner.
-The 14 was marked through and 16 was handwritten above the entry with handwritten instructions to start 03/31/23.
-There was documentation of administration each day at 5:00pm 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 dinner.
-There was documentation Novolog Flexpen 14 units was administered each day at 5:00pm 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 Assistant to the Administrator on 05/08/23 at 5:15pm.

c. Review of Resident #3's current FL-2 dated

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C 330	Continued From page 21 02/01/23 revealed a physician's order for Basaglar 40 units to be administered each night at bed time. (Basaglar is a long-acting insulin used to control blood sugar levels.) Review of Resident #3's physicians order dated 09/16/22 revealed Lantus was to be increased to 38 units each day.(Lantus is a long-acting insulin used to control blood sugar levels.) Review of Resident #3's physicians order dated 12/28/22 revealed Lantus was to be increased to 40 units each day. Review of Resident #3's physicians order dated 01/30/23 revealed Lantus was to be increased to 42 units each day. Review of Resident #3's physicians order dated 03/31/23 revealed Lantus 46 units was to be administered each day. Review of Resident #3's medication administration record (MAR) for March 2023 revealed: -There was a computerized entry for Basaglar 38 units that was marked through with a hand written 40 over the units to be administered with dinner. -There was documentation of administration each day at 5:00pm from 03/01/23 to 03/31/23. Review of Resident #3's MAR for April 2023 revealed: -There was a computerized entry for Basaglar 38 units to be administered every day and was scheduled for 8:00pm.. -The 38 was marked through, and a hand written 42 was also marked through with a hand written 46 handwritten over the units to be administered. -There was documentation of administration each	C 330		

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C 330	Continued From page 22 day at 5:00pm from 04/01/23 to 04/30/23. Review of Resident #3's MAR for May 2023 revealed: -There was a computerized entry for Basaglar with hand written 46 units to be administered each day. -There was documentation Basaglar 46 units was administered each day at 8:00pm on 05/01/23 to 05/04/23. Interview with Resident #3 on 05/08/23 at 1:12pm revealed: -Her FSBS ran high daily; usually over 200. -She gave herself insulin injections but sometimes the staff would do it. -Her insulins were in a pen delivery system and the staff would dial in the dose for each medication before giving she gave the injection to herself. -She did not know there was a second cap covering the needle and she nor the staff removed the small cap prior to injecting the medication before 05/05/23. -She woke up on 05/07/23 and didn't feel well; she was pouring sweat and felt like she was floating. -She pulled the call bell for staff to assist her and asked the MA to walk behind her in case she fell as they walked to the kitchen. -Her FSBS was 50 and she was given orange juice that helped her feel a little better. Interview with the 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. -Both long and short acting insulins had been increased several times in an effort to control the	C 330		

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blood sugar levels.
-Uncontrolled diabetes caused damage to small blood vessels including the heart and eyes.
-Blood sugar levels that were too low could lead to dizziness, falls and possibly coma.
-Blood sugar levels that were too high could lead to diabetic ketoacidosis (DKA) due to the breakdown of fat too quickly and the body would become toxic, requiring hospitalization.
-Blood sugars that run too low or too high could be life threatening.

Interview with the facility's contracted pharmacist on 05/08/23 at 2:15pm revealed:
-Resident #3 was ordered both long and short acting insulins that were administered by injection via a pen device on 11/02/21.
-Whether Resident #3 received Lantus or Basaglar and Humalog or Novolog depended on what insurance would agree to pay for and the medications were used interchangeably.
-Not receiving the insulins as ordered would cause blood glucose to not be controlled.
-Uncontrolled diabetes caused damage to blood vessels that could lead to decreased vision and heart problems such as stroke.

Second interview with a MA on 05/08/23 at 1:25pm revealed:
-Resident #3 had been on insulins by pen delivery system for quite a while but she was not sure of the date.
-She thought the facility RN conducted diabetes training every 3 months but removing the caps of the needle was not included in the training.
-She did not ask for any additional training on the pen because she thought they were using it correctly.

Interview with a second MA on 05/08/23 at

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C 330	Continued From page 24 11:20am revealed: -Resident #3's FSBS consistently ran in the 200's to 300's range. -She thought Resident #3's insulins may have been dispensed in a vial and administered by syringe when she began working approximately one and a half years ago but she was not sure. -She completed diabetic training yearly that was taught by the facility RN, but the training did not include the administration of medications only signs and symptoms to watch for if the blood sugar was too high or too low. -She received training from the RN on the administration of insulin using the pen, but she did not remember when that training was. -The training using the pen delivery system included putting a new needle on each time but did not include uncapping the needle prior to injection. -She had administered both the long and short acting insulins to the residents using the same type delivery system that used the same needles. -She did not know there was a second cap over the needle that needed to be removed and she did not know the residents did not receive the medications through the capped needle. -The facility RN conducted a training on 05/05/23 and she (MA) administered medications on 05/06/23 and 05/07/23. -Resident #3 rang her call bell on 05/07/23 saying she did not feel well. -Resident #3 was very sweaty and her FSBS was found to be 50 at about 8:55am. -She gave Resident #3 orange juice and some grapes and rechecked her FSBS at 10:00am with result of 100. Attempted telephone interview with Resident #3's primary care provider (PCP) on 05/08/23 at 9:16am was unsuccessful.	C 330		

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C 330	Continued From page 25 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 Assistant to the Administrator on 05/08/23 at 5:15pm. 2. Review of Resident #1's current FL-2 dated 06/30/22 revealed: -Diagnoses included diabetes. -There was documentation he was intermittently disoriented. -There was an order for fingerstick blood sugar (FSBS) checks three times each day. -There was an order for Tresiba FlexTouch 38 units to be administered by injection each day at bedtime. (Tresiba is a long acting insulin used to lower blood glucose.) Review of Resident #1's current assessment and care plan date 07/15/22 revealed Resident #1 was totally dependant on staff assistance for bathing. Review of Resident #1's lab report dated 06/14/22 revealed a hemoglobin A1C of 6.0. (According to the American Diabetes Association, a hemoglobin A1C value of 5.7 to 6.4 is prediabetes and a value of 6.5 and above is in the diabetic range. The goal range for people living with diabetes is less than 7.) Review of Resident #1's lab report dated 10/17/22 revealed a hemoglobin A1C of 6.4. Review of Resident #1's medication administration record (MAR) for March 2023	C 330		

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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 03/01/23 to 03/31/23.

Review of Resident #1's flowsheet for March 2023 revealed:
-There was documentation Resident #1's FSBS was checked three times each day at breakfast, lunch and dinner.
-There was documentation FSBS ranged from 136 to 227 at breakfast.
-There was documentation FSBS ranged from 71 to 294 at lunch.
-There was documentation FSBS ranged from 93 to 284 at dinner.

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.

Review of Resident #1's flowsheet for April 2023 revealed:
-There was documentation Resident #1's FSBS was checked three times each day at breakfast, lunch and dinner.
-There was documentation FSBS ranged from 144 to 217 at breakfast. (Range is approximate based on legibility of documentation.)
-There was documentation FSBS ranged from 84

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to 214 at lunch. (Range is approximate based on legibility of documentation.)
-There was documentation FSBS ranged from 121 to 371 at dinner. (Range is approximate based on legibility of documentation.)

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.

Review of Resident #1's flowsheet for May 2023 revealed:
-There was documentation Resident #1's FSBS was checked three times each day at breakfast, lunch and dinner.
-There was documentation FSBS ranged from 77 to 203 at breakfast.
-There was documentation FSBS ranged from 126 to 179 at lunch.
-There was documentation FSBS ranged from 110 to 186 at dinner.

Interview with Resident #1 on 05/08/23 at 6:34pm revealed:
-He gave himself Tresiba using the pen delivery system at night and his wife would give it when he went home for visits.
-One cap was removed from the needle and the plastic tip was pressed to his skin for administration.
-he felt better since staff began administering his medication on 05/05/23.
-His blood sugars ran in the 200s prior to 05/06/23 and has been running in the 100s since the staff began administering the Tresiba.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 28 Attempted telephone interview with Resident #1's primary care provider (PCP) on 05/08/23 at 9:16am was unsuccessful. 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 Assistant to the Administrator on 05/08/23 at 5:15pm. _____ Telephone interview with the Registered Nurse (RN) for the facility on 05/05/23 at 4:05pm revealed: -She was responsible for educating facility staff. -She remembered completing an in-service with the MAs individually when the residents were initially prescribed insulins to be administered via the pen delivery system, but she did not recall the date. -The in-service included the procedure for administering medications by injection and how to place needle and dial up the dose using the pen delivery system. -The in-service did not include uncapping the needle for administration. -She was not aware staff did not know about removing the second cap to expose the needle prior to the administration of the medications. Interview with the facility Manager on 05/08/23 at 4:45pm revealed: -The facility RN was responsible for education and trainings. -The staff received diabetic education yearly. -The full procedure, including the uncapping of the needle should have been included in the training for administration of insulin using the pen	C 330		

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C 330	Continued From page 29 delivery system to ensure staff administered the medications properly when the insulin pens were ordered. -He was not sure exactly what the training consisted of. -He did not know staff had not been exposing the needle for proper administration of the insulin medications. -It was important residents received their medications as ordered by the provider to keep them healthy. Interview with the Assistant to the Administrator on 05/08/23 at 5:15pm revealed: -The facility RN was responsible for training the MAs to ensure they were administering medications competently. -He expected each step of administering medications by pen delivery system, including uncapping, to be covered during training. _____ The facility failed to administer insulin injections to sampled insulin dependant residents which caused high blood sugars which could damage to the heart. High blood sugar could have caused the Residents to develop a life-threatening condition. The failure placed the residents at substantial risk for serious physical harm , illness and death and constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/05/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 7, 2023.	C 330		

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C 342	Continued From page 30	C 342		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#3) who had several dose changes ordered for a medication used to control blood sugar. The findings are: Review of the facility's Medication Administration Policy (not dated) revealed medications should be	C 342		

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C 342	Continued From page 31	C 342		

administered in accordance with the prescribing practitioner's orders.

Review of Resident #3's current FL-2 dated 02/01/23 revealed:
-Diagnoses included diabetes type II.
-There was no information documented for orientation status.
-There was an order for diabetic testing 4 times daily.

Review of Resident #3's lab report dated 12/28/22 revealed her hemoglobin A1C was 8.2.

Review of Resident #3's lab report for 03/31/23 revealed her hemoglobin A1C was 8.5.

Review of Resident #3's flowsheet for February 2023 revealed:
-There was documentation Resident #3's fingerstick blood sugar (FSBS) was checked four times each day at breakfast, lunch, dinner and bedtime.
-The FSBS ranged from 100 to 146 before breakfast.
-The FSBS ranged from 123 to 269 before lunch.
-The FSBS ranged from 168 to 423 before dinner.
-The FSBS ranged from 150 to 344 at bedtime.

Review of Resident #3's flowsheet for March 2023 revealed:
-There was documentation Resident #3's FSBS was checked four times each day at breakfast, lunch, dinner and bedtime.
-The FSBS ranged from 106 to 194 before breakfast.
-The FSBS ranged from 137 to 276 before lunch.
-The FSBS ranged from 144 to 366 before dinner.

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C 342	Continued From page 32 -The FSBS ranged from 125 to 359 at bedtime. Review of Resident #3's flowsheet for April 2023 revealed: -There was documentation Resident #3's FSBS was checked four times each day at breakfast, lunch, dinner and bedtime. -The FSBS ranged from 106 to 194 before breakfast. -The FSBS ranged from 137 to 276 before lunch. -The FSBS ranged from 144 to 366 before dinner. -The FSBS ranged from 125 to 359 at bedtime. Review of Resident #3's flowsheet for May 2023 revealed: -There was documentation Resident #3's FSBS was checked four times each day at breakfast, lunch, dinner and bedtime. -The FSBS ranged from 80 to 172 before breakfast. -The FSBS ranged from 50 to 225 before lunch. -The FSBS ranged from 113 to 331 before dinner. -The FSBS ranged from 103 to 314 at bedtime. 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. (Novolog is a short-acting insulin used to control blood sugar levels.) 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. Review of Resident #3's physicians order dated 12/28/22 revealed an order to increase Humalog to 12 units with breakfast and lunch each day.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 33 (Humalog is a short acting insulin used to control blood sugar levels.) Review of Resident #3's physicians order dated 03/31/23 revealed: -Humalog 14 units were to be administered by injection with breakfast and lunch each day. -There was documentation that Novolog could be given depending on insurance coverage. Review of Resident #3's medication administration record (MAR) for March 2023 revealed: -There was a computerized entry for Novolog Flexpen 12 units to be administered with breakfast and lunch. -There was documentation of administration each day at 8:00am and 12:00pm from 03/01/23 to 03/31/23. Review of Resident #3's MAR for April 2023 revealed: -There was a computerized entry for Novolog Flexpen 12 units to be administered with breakfast and lunch. -The 12 was marked through and 14 was handwritten above the entry and 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	C 342		

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C 342	Continued From page 34 to 05/04/23. Refer to telephone interview with the Registered Nurse (RN) for Resident #3's primary care provider's (PCP) office on 05/08/23 at 9:25am. Refer to interview with the MA on 05/8/23 at 11:20am. Refer to interview with a second MA on 05/08/23 at 1:25pm. Refer to interview with the facility Manager on 05/08/23 at 10:05am. Refer to interview with the Assistant to the Administrator on 05/08/23 at 4:15pm. b. Review of Resident #3's current FL-2 dated 02/01/23 revealed a physician's order for Basaglar 40 units to be administered each night at bed time. (Basaglar is a long acting insulin used to control blood sugar levels.) Review of Resident #3's physicians order dated 09/16/22 revealed Lantus was to be increased to 38 units each day. (Lantus is long-acting insulin used to control blood sugar levels.) Review of Resident #3's physicians order dated 12/28/22 revealed Lantus was to be increased to 40 units each day. Review of Resident #3's physicians order dated 01/30/23 revealed Lantus was to be increased to 42 units each day. Review of Resident #3's physicians order dated 03/31/23 revealed: Lantus 46 units was to be administered each day.	C 342		

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C 342	Continued From page 35 Review of Resident #3's medication administration record (MAR) for March 2023 revealed: -There was a computerized entry for Basaglar 38 units that was marked through with a hand written 40 over the units to be administered with dinner. -There was documentation of administration each day at 5:00pm from 03/01/23 to 03/31/23. Review of Resident #3's MAR for April 2023 revealed: -There was a computerized entry for Basaglar 38 units to be administered with dinner. -The 38 was marked through, and a hand written 42 was also marked through with a hand written 46 handwritten over the units to be administered. -There was documentation of administration each day at 5:00pm from 04/01/23 to 04/30/23. Review of Resident #3's MAR for May 2023 revealed: -There was a computerized entry for Basaglar with hand written 46 units to be administered each day. -There was documentation Basaglar 46 units was administered each day at 8:00pm on 05/01/23 to 05/04/23. Attempted telephone interview with Resident #3's primary care provider on 05/05/23 at 12:15pm and 1:35pm and again on 05/08/23 at 9:16am was unsuccessful. Refer to telephone interview with the Registered Nurse (RN) for Resident #3's primary care provider's (PCP) office on 05/08/23 at 9:25am. Refer to interview with the MA on 05/8/23 at 11:20am.	C 342		

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C 342	Continued From page 36 Refer to interview with a second MA on 05/08/23 at 1:25pm. Refer to interview with the facility Manager on 05/08/23 at 10:05am. Refer to interview with the Assistant to the Administrator on 05/08/23 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 administer medications as ordered. -Both Long and short acting insulins had been increased several times in an effort to control the blood sugar levels. -Uncontrolled diabetes caused damage to small blood vessels including the heart and eyes. -Blood sugar levels that were too low could lead to dizziness, falls and possibly coma. -Blood sugar levels that were too high could lead to diabetic ketoacidosis (DKA) due to the breakdown of fat too quickly and the body would become toxic, requiring hospitalization. -Blood sugars that run too low or too high could be life threatening. Interview with a medication aide (MA) on 05/08/23 at 11:20am revealed: -Medication orders should be clear and accurate on the MAR to ensure residents' received the medication as ordered by the physician. -She marked through dose changes when the dose was changed for a medication, but she did not remember what the dates for the changes	C 342		

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C 342	Continued From page 37	C 342		

were for Resident #3 and was unable to tell what doses were given on which dates by looking at the MARs.
-She did not know she should not mark through a dose each time the dose changed.
-The facility RN completed her MA training and she may have taught the process for correctly changing medications on the MAR but she did not remember.

Interview with a second MA on 05/08/23 at 1:25pm revealed:
-She had oversight of the other MAs and her duties included ensuring medications were administered as ordered including ensuring new orders and medication changes were on the MAR accurately.
-Any new orders for dose changes should be re-written in a blank box on the MAR and documentation that a change had occurred should be made in the administration documentation portion beside the discontinued medication.
-She was unable to tell what dose of the prescribed insulins were administered on each day by reviewing Resident #3's MARs.
-She was not aware the MA was marking through and overwriting the dose when the medication dose changed.
-There was no process in place for reviewing MARs for accuracy.
-The process for changing medication orders on the MAR was taught in MA training by the facility RN.

Interview with the facility Manager on 05/08/23 at 10:05am revealed:
-He expected MARs to be clear and accurate.
-He and the Assistant Administrator were responsible for reviewing MARs for accuracy but

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C 342	Continued From page 38 audits had not been completed since sometime in March 2023 when the Administrator was on leave of absence. -Staff were trained on the proper way to transcribe orders upon hire. -He was not aware the MA had marked through doses instead of transcribing the order in a new block as she was taught. -He thought the MA may have taken a short cut to save time because of added responsibilities or maybe that was how orders were done at another facility she worked for. Interview with the Assistant to the Administrator on 05/08/23 at 4:15pm revealed: -MARs should be accurate for proper administration of medications and should reflect clearly what was administered. -He usually reviewed resident records and MARs monthly but he had not in a couple of months because of personal concerns. -He thought staff knew what they should do, how to do it and were doing it correctly. _____ The facility failed to ensure medication administration records were accurate related to the dose of insulin that was to be administered to a resident with uncontrolled diabetes which increased the risk of life-threatening conditions associated with uncontrolled blood sugar levels. The facility's failure to ensure the accuracy of the medication administration record was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/08/23 for this violation. THE CORRECTION DATE FOR THE TYPE B	C 342		

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C 342	Continued From page 39 VIOLATION SHALL NOT EXCEED JUNE 22, 2023.	C 342		
C 350	10A NCAC 13G .1005 (a and b) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) The facility shall notify the physician when: (1) there is a change in the resident's mental or physical ability to self-administer; (2) the resident is non-compliant with the physician's orders; or (3) the resident is non-compliant with the facility's medication policies and procedures. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to ensure an assessment and physician's order was in place for 3 of 3 sampled residents (#1, #2, #3) who self-administered medications used to control blood sugar by	C 350		

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C 350	Continued From page 40 injection (#1, #2, #3). The findings are: Review of the facility's Resident Self-Administration of Medication policy (not dated) revealed: -The Resident would be competent and physically able to self-administer medications. -There would be a self-administration order by a physician or other legally authorized person to prescribe. -The order would be kept in the resident's record. 1. Review of Resident #3's current FL-2 dated 02/01/23 revealed: -Diagnoses included diabetes type II. -There was no information documented for orientation status. Review of Resident #3's Resident Register revealed an admission date of 04/01/19. Review of Resident #3's current assessment and care plan dated 07/15/22 revealed: -Resident #3 required extensive assistance from staff for injections four times each day. -Resident #3's vision was limited and she wore glasses. Review of Resident #3's Licensed Health Professional Support (LHPS) dated 04/03/23 revealed: -The LHPS was signed by the Registered Nurse (RN) for the facility. -There was documentation Resident #3 had "blood glucose 300 on insulin and oral glycemic medications". -LHPS tasks included blood glucose monitoring. -There was no documentation for LHPS task of	C 350		

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C 350	Continued From page 41 administering medications 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. 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. Review of Resident #3's physicians order dated 12/28/22 revealed an order to increase Humalog to 12 units with breakfast and lunch each day. (Humalog is short-acting insulin used to control blood sugar levels.) Review of Resident #3's physicians order dated 03/31/23 revealed: -Humalog 14 units were to be administered by injection with breakfast and lunch each day. -There was documentation that Novolog could be given depending on insurance coverage. Review of Resident #3's medication administration record (MAR) for March 2023 revealed: -There was a computerized entry for Novolog Flexpen 12 units to be administered with breakfast and lunch. -There was documentation of administration each day at 8:00am and 12:00pm from 03/01/23 to 03/31/23. Review of Resident #3's MAR for April 2023	C 350		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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revealed:
-There was a computerized entry for Novolog Flexpen 12 units to be administered with breakfast and lunch.
-The 12 was marked through and 14 was 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.

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.

Review of Resident #3's physicians order dated 03/31/23 revealed Humalog 16 units was to be administered by injection each evening with dinner.

Review of Resident #3's medication

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administration record (MAR) for March 2023 revealed:
-There was a computerized enter for Novolog Flexpen 14 units to be administered with dinner.
-There was documentation of administration each day at 5:00pm from 03/01/23 to 03/31/23.

Review of Resident #3's MAR for April 2023 revealed:
-There was a computerized entry for Novolog Flexpen 14 units to be administered with dinner.
-The 14 was marked through and 16 was handwritten above the entry with handwritten instructions to start 03/31/23.
-There was documentation of administration each day at 5:00pm 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 dinner.
-There was documentation Novolog Flexpen 14 units was administered each day at 5:00pm on 05/01/23 to 05/04/23.

c. Review of Resident #3's current FL-2 dated 02/01/23 revealed a physician's order for Basaglar 40 units to be administered each night at bed time. (Basaglar is a long-acting insulin used to control blood sugar levels.)

Review of Resident #3's physicians order dated 09/16/22 revealed Lantus was to be increased to 38 units each day.(Lantus is a long-acting insulin used to control blood sugar levels.)

Review of Resident #3's physicians order dated 12/28/22 revealed Lantus was to be increased to 40 units each day.

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C 350	Continued From page 44 Review of Resident #3's physicians order dated 01/30/23 revealed Lantus was to be increased to 42 units each day. Review of Resident #3's physicians order dated 03/31/23 revealed Lantus 46 units was to be administered each day. Review of Resident #3's medication administration record (MAR) for March 2023 revealed: -There was a computerized entry for Basaglar 38 units that was marked through with a hand written 40 over the units to be administered with dinner. -There was documentation of administration each day at 5:00pm from 03/01/23 to 03/31/23. Review of Resident #3's MAR for April 2023 revealed: -There was a computerized entry for Basaglar 38 units to be administered every day and was scheduled for 8:00pm.. -The 38 was marked through, and a hand written 42 was also marked through with a hand written 46 handwritten over the units to be administered. -There was documentation of administration each day at 5:00pm from 04/01/23 to 04/30/23. Review of Resident #3's MAR for May 2023 revealed: -There was a computerized entry for Basaglar with hand written 46 units to be administered each day. -There was documentation Basaglar 46 units was administered each day at 8:00pm on 05/01/23 to 05/04/23. Interview with Resident #3 on 05/08/23 at 1:12pm revealed: -Her FSBS ran high daily; usually over 200.	C 350		

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-She gave herself insulin injections but sometimes the staff would do it.
-Her insulins were in a pen delivery system and the staff would dial in the dose for each medication before giving she gave the injection to herself.
-She did not know there was a second cap covering the needle and she nor the staff removed the small cap prior to injecting the medication before 05/05/23.

Interview with the Supervisor in Charge (SIC)/medication aide (MA) on 05/05/23 at 1:56pm revealed:
-Resident #3 usually administered her Humalog and Lantus to herself but sometimes staff would administer the injections.
-She did not know if there was an order for Resident #3 to be able to self administer the injection.

Attempted telephone interview with Resident #3'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 with the Assistant to the Administrator on 05/08/23 at 5:15pm.

2. Review of Resident #1's current FL-2 dated 06/30/22 revealed:

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-Diagnoses included diabetes.
-There was documentation he was intermittently disoriented.
-There was an order for fingerstick blood sugar checks three times each day.
-There was an order for Tresiba FlexTouch 38 units to be administered by injection each day at bedtime.

Review of Resident #1's Resident Register revealed he was admitted on 06/05/08.

Review of Resident #1's current assessment and care plan date 07/15/22 revealed:
-Resident #1 required limited assistance from staff for eating and dressing.
-Resident #1 required extensive assistance from staff for grooming.
-Resident #1 was totally dependant on staff assistance for bathing.

Review of Resident #1's resident record revealed there was no physician's order for self-administration of any medication.

Review of Resident #1's medication administration record (MAR) for March 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 03/01/23 to 03/31/23.

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

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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.

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.

Interview with Resident #1 on 05/08/23 at 6:34pm revealed:
-He gave himself Tresiba using the pen delivery system at night and his family member would give it when he went home for visits.
-One cap was removed from the needle and the plastic tip was pressed to his skin for administration.
-He felt better since staff began administering his medication on 05/05/23.
-His blood sugars ran in the 200s prior to 05/06/23 and has been running in the 100s since the staff began administering the Tresiba.

Interview with the Supervisor in Charge (SIC)/medication aide (MA) on 05/05/23 at 1:56pm revealed:
-Resident #1 gave himself his Tresiba injection each night and had been giving himself injections since before he was admitted to the facility.
-She did not know if there was an order for Resident #1 to be able to self administer the injection.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 05/08/23 at

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C 350	Continued From page 48 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 with the Assistant to the Administrator on 05/08/23 at 5:15pm. 3. Review of Resident #2's current FL-2 dated 12/15/22 revealed: -Diagnoses included mild intellectual disability, bipolar disorder and diabetes type II. -There was an order for Trulicity 1.5/0.5ml , 1 syringe to be injected every Tuesday. Review of Resident #2's Resident Register revealed: -Resident #2 was admitted on 11/18/21. -Resident #2 wore glasses due to limited vision. Review of a physician's order dated 04/26/23 revealed Trulicity 3mg/0.5ml, 1 syringe was to be injected every Wednesday. Review of Resident #2's resident record revealed there was no documentation of a physician's order for self-administration of any medication. Review of Resident #2's medication administration record (MAR) for March 2023 revealed: -There was a computerized entry for Trulicity 3mg/0.5ml, 1 syringe was to be injected every	C 350		

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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 documentation of administration on 05/03/23.

Interview with Resident #2 on 05/05/23 at 6:05pm revealed:
-She gave herself the weekly injection of Trulicity that came in a single use pen.
-She was taught by her primary care provider how to administer the medication by injection.

Interview with the Supervisor in Charge (SIC)/medication aide (MA) on 05/05/23 at 1:56pm revealed:
-Resident #2 always gave herself the Trulicity injection each week and the pens were single dose.
-Resident #2 was taught how to give the injection at the doctor's office.
-She did not know if there was an order for

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C 350	Continued From page 50 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 with the Assistant to the Administrator on 05/08/23 at 5:15pm. _____ Interview with the Supervisor in Charge (SIC)/medication aide (MA) on 05/05/23 at 1:56pm revealed: -Only insulins were self-administered by the residents. -She was not aware residents needed to have a physician's order in place to self-administer medications. Telephone interview with the facility's contracted pharmacy on 05/08/23 at 2:15pm revealed: -Residents should be assessed to ensure they were capable prior to self-administering medications. -Without ensuring a resident was capable of self-administering medications, the resident may not receive the correct dose or, if administered by injection, could cause infection if not given correctly.	C 350		

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C 350	Continued From page 51 Interview with the facility Manager on 05/08/23 at 4:45pm revealed: -He thought self-administration orders were in place for the residents on insulin. -He thought the residents' prescribing physician taught them how to give the injections to themselves. -He thought the residents were capable of administering their insulins by injection after the MA dialed up the dose. Interview with the Assistant to the Administrator on 05/08/23 at 5:15pm revealed: -He did not know staff were not aware an order for self administration was required. -The prescriber would be responsible for assessing whether a resident was able to self administer medications prior to writing the order. -He thought the self-administration orders were in place for the Residents that self-administered their insulin by injection.	C 350		