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D 000	Initial Comments The Adult Care Licensure Section and Robeson County Department of Social Services conducted an annual and follow up survey on January 23-25, 2024.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by the provider for 2 of 7 sampled residents (#4 and #5) including a long-acting insulin and sliding scale insulin (#4) and mood stabilizing and antidepressant medications (#5). The findings are: Review of the facility's Medication Services/Pharmaceutical Care Services Policy and Procedures dated September 2021 revealed: -Administration of any medication order specified by the prescriber as "emergency" or "STAT" shall be started within 2 hours of said order. -All medications not categorized above (emergency, STAT, antibiotic) shall be considered	D 358		

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routine and if ordered prior to 5:00pm shall be started with the next regularly scheduled dose following the next regularly scheduled pharmacy delivery.
-Orders received after 5:00pm shall be started no later than the regularly scheduled dose following the regularly scheduled pharmacy delivery of the next business day.
-All orders were reviewed by the Resident Care Coordinator (RCC) or designee.
-Orders must be complete. If incomplete, contact the prescriber for clarification immediately.
-The RCC (medication aide (MA) if after hours/weekends) faxed the order to the pharmacy and scanned the order into the electronic scan.
-The RCC or designee waited for the order to be placed in the electronic medication system for approval and then approved the order for administration and followed the steps in the order process system.
-MAs reviewed the Facility Activity Report at the beginning of each shift for order changes when a new order or changed order was received.
-The order process system included yellow, orange, red, blue, and green folders for processing orders.
-Yellow: order was received, faxed to pharmacy, and awaiting approval.
-Orange: Waiting on delivery; if delivered moved to the green folder and if not place in the red folder.
-Red: Order was incomplete and required provider clarification, physical prescription was needed, or prior authorization was required from the provider. Follow up immediately.
-Blue: Non- medication orders.
-Green: Ready to scan into the electronic medication system.
-Delivered medications were compared to the

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delivery manifest and the delivery manifest was signed, dated, and faxed to the pharmacy.
-Residents medication orders were checked weekly by completing a cart audit.
-Staff checked to see that all medications were available using a copy of the physician's orders.
-Staff re-ordered as needed and the re-order was placed in the order processing system for follow up.
-Staff signed and dated the physician's orders once the cart audit was completed and left for the lead MA/RCC to review.

1. Review of Resident #4's current FL-2 dated 01/17/24 revealed diagnoses included type II diabetes mellitus.

a. Review of Resident #4's FL-2 dated 01/17/24 revealed an order for Levemir 40 units twice daily (Levemir is a long-acting insulin used to control blood sugar levels).

Review of Resident #4's November and December 2023 electronic medication administration records (eMARs) revealed:
-There was an entry for Levemir 40 units twice daily at 8:00am and 8:00pm.
-There was documentation Levemir 40 units was administered twice daily 11/01/23 through 12/31/23 at 8:00am and 8:00pm.

Review of Resident #4's January 2024 eMAR revealed:
-There was an entry for Levemir 40 units twice daily at 8:00am and 8:00pm dated 05/01/23 to 01/11/24.
-There was documentation Levemir was administered twice daily 01/01/24 to 01/10/24 and at 8:00am on 01/11/24.
-There was a second entry for Levemir 40 units

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twice daily at 8:00am and 8:00pm dated 01/11/24 to 01/18/24.
-There was documentation Levemir was administered at 8:00pm on 01/11/24, twice daily 01/12/24 to 01/17/24, and at 8:00am on 01/18/24.
-There was a third entry for Levemir 40 units twice daily at 8:00am and 8:00pm dated 01/18/24 to 01/20/24.
-There was documentation Levemir was administered at 8:00pm on 01/18/24, 8:00am and 8:00pm on 01/19/24, and at 8:00pm on 01/20/24.

Observation of Resident #4's medications on hand on 01/24/24 at 2:53pm revealed there was no Levemir on hand for Resident #4.

Review of Resident #4's electronic progress note dated 01/12/24 revealed Resident #4's FSBS level was 439 at 7:11pm and the primary care provider (PCP) was notified (Normal blood sugar levels range from 70 to 100).

Interview with Resident #4 on 01/24/24 at 6:30pm revealed:
-He received 2 insulin shots every morning, one at lunch and 2 every evening.
-He had some high blood sugar readings a few weeks back, but the blood sugar levels were better now.
-He did not know what caused his blood sugar levels to be high.

Interview with a MA on 01/24/24 at 4:47pm revealed:
-Resident #4 was out of Levemir for his 8:00pm dose and she called the pharmacy asking why refills had not been sent.
-She did not remember the date Resident #4 ran out of Levemir and she called the pharmacy.
-When she called the pharmacy, she found out

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Levemir was discontinued by the manufacturer.
-She called Resident #4's PCP's office that same evening and spoke with the on-call provider who told her a new order would have to be obtained from the PCP the following morning.

Interview with a second MA on 01/25/24 at 11:55am revealed:
-Resident #4 had extra Levemir pens when the pharmacy dispensed his Levemir pens in December 2023; he did not know how many extra pens.
-Resident #4 did not run out of Levemir.
-He administered Levemir to Resident #4 until the order was changed.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/24/24 at 3:53pm revealed:
-The original order from May 2023 for Resident #4 was for Levemir 40 units twice daily.
-The pharmacy dispensed 15ml or 1500 units of Levemir in 5 pens with 300 units per pen which was an 18-day supply on 11/07/23, 11/27/23 and 12/19/23 for Resident #4.
-The manufacturer discontinued Levemir so there was none dispensed after 12/19/23.
-The pharmacy received an order dated 01/18/24 for a new long-acting insulin for Resident #4.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/25/24 at 2:58pm revealed:
-At 80 units total per day and 300 units per pen, one Levemir or Lantus (equal) pen would last Resident #4 3.75 days.
-One pen might last 4 days because there was a little extra insulin in each pen.

Based on Resident #4's pharmacy dispensing

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history for Levemir and telephone interview with the pharmacist, Levemir dispensed on 11/07/23 would have lasted 18 days or until 11/25/23, Levemir dispensed on 11/27/23 would have lasted 18 days or until 12/15/23, and Levemir dispensed on 12/19/23 would have lasted 18 days or until 01/06/24.

Interview with the RCC on 01/25/24 at 3:12pm revealed:
-She thought Resident #4 still had Levemir on hand around 01/18/24.
-She was not aware of Levemir being borrowed from any resident for Resident #4.
-She was able to enter medication orders on the eMAR.
-Any changes she made to the eMAR were not visible to the pharmacy on their side of the electronic medication system.
-All new orders were faxed to the pharmacy for the pharmacy to enter on the eMAR; otherwise, it created confusion.
-Pharmacy puts a new entry for the same medication whenever a refill was requested, so there would be 2 entries on the eMAR for the same medication.
-The Levemir entries on Resident #4's January 2024 eMAR looked as if a refill of Levemir was requested on 01/11/24.
-The refill request caused the initial eMAR entry for Levemir to be discontinued and generated a new Levemir entry.
-A second refill request was made generating the third Levemir entry on Resident #4's January 2024 eMAR.
-Refill requests were the only thing that generated additional entries of the same medication order.

Interview with the Administrator on 01/25/24 at 3:43pm revealed:

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-New entries for a medication on the eMAR were generated from refill requests.
-She did not know of any other reason for duplicated entries on the eMAR.
-She was not aware of Levemir being borrowed from another resident for Resident #4.

Telephone interview with Resident #4's PCP on 01/24/24 at 4:19pm revealed:
-She was not aware of Resident #4 running out of Levemir.
-The pharmacy requested a change in Resident #4's long-acting insulin on 01/18/24 because the manufacturer discontinued Levemir.

Refer to interview with a medication aide (MA) on 01/25/24 at 11:55am.

Refer to interview with the Resident Care Coordinator (RCC) on 01/24/24 at 5:07pm.

Refer to interview with the Administrator on 01/24/24 at 5:00pm.

b. Review of Resident #4's prescription order dated 01/18/24 revealed:
-There was an order to discontinue Levemir for insurance preference.
-There was an order for Lantus 40 units twice daily. (Lantus is a long-acting insulin used to control blood sugar levels.)

Review of Resident #4's January 2024 eMAR revealed:
-There was an entry for Lantus 40 units twice daily at 8:00am and 8:00pm dated 01/19/24 to "open".
-There was documentation Lantus was administered at 8:00pm on 01/19/24, 8:00am and 8:00pm on 01/20/24 to 01/22/24, and at 8:00am

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D 358	Continued From page 7 on 01/23/24. Observation of Resident #4's medications on hand on 01/24/24 at 2:53pm revealed there was no Lantus on hand. Interview with Resident #4 on 01/24/24 at 6:30pm revealed: -He received 2 insulin shots every morning, one at lunch and 2 every evening. -He had some high blood sugar readings a few weeks back, but the blood sugar levels were better now. -He did not know what caused his blood sugar levels to be high. Interview with a MA on 01/24/24 at 4:47pm revealed: -Resident #4 did not have any Lantus on hand and available for administration. -She documented administering Lantus at 8:00pm on 01/19/24 to 01/21/24 to Resident #4 because she borrowed one pen from another resident who did not need it. -She used the last of the Lantus insulin pen last evening (8:00pm on 01/23/24). -She did not remember when she borrowed the Lantus. -She did not document borrowing the Lantus pen from another resident. -She did not notify Resident #4's primary care provider (PCP) that Resident #4 needed Lantus because everyone already knew Resident #4 did not have Lantus insulin of his own. -The first shift MA administered Lantus every morning to Resident #4 and she thought the first shift MA would have already contacted the PCP. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/24/24 at	D 358		

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D 358	Continued From page 8 4:28pm revealed: -Due to Levemir being discontinued by the manufacturer a new long-acting insulin order was needed for Resident #4. -The order was written specifically for Lantus and not inclusive of generic versions and the brand was not covered by Resident #4's insurance. -A prior authorization form for Resident #4's Lantus was faxed to the PCP's office on 01/18/24. -An "Unable to Fill Notification" for Resident #4's Lantus was faxed to the facility on 01/18/24 and 01/19/24. -The pharmacy received a new order for Basaglar insulin on 01/24/24 from the provider which was being filled and sent to the facility (Basaglar is a long-acting insulin used to control blood sugar levels). Interview with the Resident Care Coordinator (RCC) on 01/24/24 at 5:07pm revealed: -There was a delay in getting a new order for Lantus when Levemir was discontinued. -A prior authorization was sent to the PCP's office causing a delay. -She did not contact the PCP for Resident #4's Lantus between 01/18/24 and 01/24/24 because the PCP previously told her to fax notifications and requests to the PCP's office. -A new order was received on 01/24/24 and faxed to the pharmacy. -There were 2 extra Lantus pens from a current resident in the facility that were used for Resident #4. Second interview with the RCC on 01/25/24 at 3:12pm revealed the MA used the last of the Lantus insulin that was borrowed from another resident on 01/23/24 or 01/24/24.	D 358		

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D 358	Continued From page 9 Interview with the Administrator on 01/24/24 at 5:00pm revealed she did not know Resident #4 did not have any long-acting insulin. Second interview with the Administrator on 01/25/24 at 3:43pm revealed: -Resident #4's long-acting insulin was delivered on 01/25/24. -MAs should have contacted Resident #4's PCP for clarification on what to do when he ran out of his long-acting insulin. -MAs were responsible to document contact with the PCP in the resident's electronic progress notes. -MAs were responsible for notifying her and the RCC when there was an issue with medication availability. Telephone interview with Resident #4's PCP on 01/24/24 at 4:19pm revealed: -The pharmacy requested a change in Resident #4's long-acting insulin because the manufacturer discontinued Levemir. -She was not notified of anything except the need to change the order for insurance purposes. -She would be concerned if Resident #4 had increased blood sugar result, but she did not have access to review those results at the time of the call. -Elevated blood sugar levels over a long period of time could lead to end organ damage (damage to major organs including heart, brain, kidneys, and eyes). -She expected medications to be administered as ordered. Refer to interview with a medication aide (MA) on 01/25/24 at 11:55am. Refer to interview with the Resident Care	D 358		

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D 358	Continued From page 10 Coordinator (RCC) on 01/24/24 at 5:07pm. Refer to interview with the Administrator on 01/24/24 at 5:00pm. c. Review of Resident #4's FL-2 dated 01/17/24 revealed: -There was an order for finger stick blood sugar (FSBS) checks four times daily, before meals and at bedtime. -There was an order for Novolin sliding scale insulin (SSI) as follows: for FSBS result of 81-100 give 6 units, 101-199 give 12 units, 200-250 give 13 units, 251-300 give 14 units, 301-350 give 15 units, 351-400 give 16 units, 401-450 give 17 units and greater than 450 call the PCP. (Novolin is a fast-acting insulin used to lower blood sugar levels.) Review of Resident #4's November 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Novolin SSI as follows: for FSBS result of 81-100 give 6 units, 101-199 give 12 units, 200-250 give 13 units, 251-300 give 14 units, 301-350 give 15 units, 351-400 give 16 units, 401-450 give 17 units and greater than 450 call the PCP. -There were 120 FSBS results documented ranging from 106-275 with 120 opportunities for SSI. -There was documentation 12 units of SSI was administered for 6 FSBS results ranging from 200-275. -On 11/02/23 at 7:45am the FSBS result was 211 and there was documentation 12 units of Novolin was administered instead of the 13 units ordered. -On 11/03/23 at 11:45am the FSBS result was 201 and there was documentation 12 units of Novolin was administered instead of the 13 units	D 358		

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ordered.
-On 11/15/23 at 11:45am the FSBS result was 275 and there was documentation 12 units of Novolin was administered instead of the 14 units ordered.
-On 11/24/23 at 7:45am the FSBS result was 216 and there was documentation 12 units of Novolin was administered instead of the 13 units ordered.
-On 11/25/23 at 11:45am the FSBS result was 213 and there was documentation 12 units of Novolin was administered instead of the 13 units ordered.
-On 11/26/23 at 11:45am the FSBS result was 200 and there was documentation 12 units of Novolin was administered instead of the 13 units ordered.

Review of Resident #4's December 2023 eMAR revealed:
-There was an entry for Novolin SSI as follows: for FSBS result of 81-100 give 6 units, 101-199 give 12 units, 200-250 give 13 units, 251-300 give 14 units, 301-350 give 15 units, 351-400 give 16 units, 401-450 give 17 units and greater than 450 call the PCP.
-There were 124 FSBS results documented ranging from 97-337 with 124 opportunities for SSI.
-There was documentation 12 units of SSI was administered for 2 FSBS results of 98 at 7:45am on 12/05/23 and 97 at 11:45am on 12/09/23 when 6 units should have been administered and for 17 FSBS results 208-289, for example 247 at 11:45am on 12/11/23, 289 at 11:45am on 12/23 and 253 at 11:45am on 12/29/23.
-There was documentation 14 units of SSI was administered for a FSBS result of 246 at 5:00pm on 12/30/23 when 13 units should have been administered; and 16 units was administered for a FSBS result of 337 at 5:00pm on 12/01/23

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when 15 units should have been administered.

Review of Resident #4's January 2024 eMAR revealed:
-There was an entry for Novolin SSI as follows: for FSBS result of 81-100 give 6 units, 101-199 give 12 units, 200-250 give 13 units, 251-300 give 14 units, 301-350 give 15 units, 351-400 give 16 units, 401-450 give 17 units and greater than 450 call the PCP.
-There were 90 FSBS results documented ranging from 102-439 with 90 opportunities for SSI.
-There was documentation 12 units of SSI was administered for 9 FSBS results ranging from 203-292.
-On 01/01/24 at 11:45am the FSBS result was 252 and there was documentation 12 units of Novolin was administered instead of the 14 units ordered.
-On 01/05/24 at 11:45am the FSBS result was 216 and there was documentation 12 units of Novolin was administered instead of the 13 units ordered.
-On 01/06/24 at 11:45am the FSBS result was 205 and there was documentation 12 units of Novolin was administered instead of the 13 units ordered.
-On 01/07/24 at 7:45am the FSBS result was 235 and there was documentation 12 units of Novolin was administered instead of the 13 units ordered.
-On 01/07/24 at 11:45am the FSBS result was 265 and there was documentation 12 units of Novolin was administered instead of the 14 units ordered.
-On 01/08/24 at 7:45am the FSBS result was 203 and there was documentation 12 units of Novolin was administered instead of the 13 units ordered.
-On 01/08/24 at 11:45am the FSBS result was 224 and there was documentation 12 units of

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Novolin was administered instead of the 13 units ordered.
-On 01/08/24 at 5:00pm the FSBS result was 292 and there was documentation 12 units of Novolin was administered instead of the 14 units ordered.
-On 01/09/24 at 11:45am the FSBS result was 235 and there was documentation 12 units of Novolin was administered instead of the 13 units ordered.

Interview with Resident #4 on 01/24/24 at 6:30pm revealed:
-He received 2 insulin shots every morning, one at lunch and 2 every evening.
-He had some high blood sugar readings a few weeks back, but the blood sugar levels were better now.
-He did not know what caused his blood sugar levels to be high.

Interview with a medication aide (MA) on 01/24/24 at 3:22pm revealed:
-The eMAR automatically documented the number of units for SSI when the FSBS result was entered.
-He did not have the option to enter the amount of SSI administered.

Interview with a MA on 01/25/24 at 11:55am revealed:
-He entered FSBS results in the eMAR system, and the system automatically generated the number of SSI units to administer.
-He did not give the 12 units documented for FSBS results from 201-250; he administered 13 units according the SSI order.
-He did not know why there was documentation on the eMAR that 13 units of SSI was administered at 7:45am on 01/20/24 for a FSBS result of 233 and 13 units at 7:45am on 01/23/24

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D 358	Continued From page 14 for a FSBS result of 270. Interview with the Resident Care Coordinator (RCC) on 01/24/24 at 5:07pm revealed: -She was unsure if the amount of SSI documented on the eMAR was an automatic entry on the eMAR. -She was unable to test the system because there was an alert on eMAR that her entry attempt was considered an early administration of a FSBS check. Second interview with the RCC on 01/25/24 at 3:12pm revealed FSBS level monitoring and SSI administration according to the provider's orders were important because FSBS levels could bottom out or be sky high and result in a coma. Interview with the Administrator on 01/24/24 at 5:00pm revealed: -MAs were responsible for administering SSI according to the sliding scale. -She was unsure if the amount of SSI documented on the eMAR was an automatic entry on the eMAR. Second interview with the Administrator on 01/25/24 at 3:43pm revealed it was important to administer insulins as ordered by the provider to maintain controlled blood sugar levels for individuals dependent on insulin. Refer to interview with a medication aide (MA) on 01/25/24 at 11:55am. Refer to interview with the Resident Care Coordinator (RCC) on 01/24/24 at 5:07pm. Refer to interview with the Administrator on 01/24/24 at 5:00pm.	D 358		

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D 358	Continued From page 15 2. Review of Resident #5's current FL-2 dated 01/17/24 revealed diagnoses included cerebral vascular accident, convulsions, and behaviors. Interview with a medication aide (MA) on 01/23/25 at 9:59am revealed: -Resident #5 had physically and verbally abusive behavior towards residents. -Resident #5's abusive behavior was usually directed towards 2 specific residents and usually occurred on second shift. -Staff checked on Resident #5 every hour and kept him separated from the other 2 specific residents. a. Review of Resident #5's current FL-2 dated 01/17/24 revealed an order for divalproex 125mg 4 capsules daily at noon. (Divalproex is used to stabilize mood disorders.) Review of Resident #5's emergency room discharge instructions dated 01/13/24 revealed: -Resident #5 was seen for suicidal and homicidal behavior. -There were instructions to start divalproex 250mg extended release (ER) daily and divalproex 500mg ER daily at bedtime. Review of Resident #5's prescription orders dated 01/15/24 revealed divalproex 250mg ER daily and divalproex 500mg ER daily at bedtime. Review of Resident #5's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for divalproex 250mg ER daily at 8:00am dated 01/18/24 to "open". -There was documentation divalproex 250mg ER was administered daily from 01/18/24 to 01/23/24	D 358		

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except on 01/20/24 when the dose was refused.
-There was an entry for divalproex 500mg ER daily at 8:00pm dated 01/17/24 to "open".
-There was documentation divalproex 500mg ER was administered daily at bedtime 01/18/24 to 01/21/24 except on 01/20/24 when the dose was refused.
-There was documentation divalproex 500mg ER was refused on 01/17/24 and 01/22/24.

Observation of Resident #5's medications on hand on 01/23/24 at 3:53pm revealed there was no divalproex on hand for Resident #5.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/23/24 at 4:00pm revealed:
-The pharmacy had a record of a current order dated 01/15/24 for divalproex 250mg extended release (ER) every morning and 500mg ER every evening for Resident #5.
-The previous order for divalproex 125mg 4 capsules was discontinued on 01/15/24.
-The pharmacy billed and dispensed medications in 7-day cycles.
-The new orders for divalproex dated 01/15/24 were not billed or dispensed for Resident #5.
-The first billing was scheduled for 01/24/24 for a start date of 01/26/24.
-She did not know why divalproex 250mg ER and 500mg ER were not dispensed for Resident #5.
-She did not see a record of staff contacting the pharmacy about Resident #5's divalproex ordered on 01/15/24.

Interview with a medication aide (MA) on 01/23/24 at 4:17pm revealed:
-Normally, she clicked on each medication listed on the eMAR when she prepared medications for administration.

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-She did not scan the barcode on the multidose pack (MDP).
-She documented administering divalproex 500mg ER at 8:00pm on 01/19/24 and 01/21/24 to Resident #5.
-She did not remember giving Resident #5 divalproex.
-She was used to administering 2 medications at 8:00pm to Resident #5.
-She did not know there was a new order for divalproex every evening.
-She did not notice the new order and did not catch the medication error.

Interview with the Resident Care Coordinator (RCC) on 01/23/24 at 4:23pm revealed:
-She did not think Resident #5 went without doses of divalproex because he had some of the capsules from the previous order still in the facility.
-She did not realize the dosage and form were different (capsules with sprinkle verses,k extended release and 125mg verses 250mg and 500mg).
-She sent a fax to the pharmacy that morning (01/23/24) requesting divalproex 250mg and 500mg because she saw the medications were not in the MDPs.
-There was a delay originally due to needing a prescription order because it was not provided from the ER on 01/13/24 (Saturday).
-She did not see the electronic message from the pharmacy until she came in to work that Monday (01/15/24).
-She contacted the mental health provider (MHP) for the prescription orders on 01/15/24 and faxed the orders to the pharmacy.
-She did not follow up an make sure the medication was on the medication cart.
-The third shift MA was responsible for checking

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D 358	Continued From page 18 MDPs against the delivery sheet each week when the pharmacy delivered the MDPs. -Medications not in the MDP on delivery were documented on the delivery sheet, faxed to the pharmacy, and left by the MA for her (RCC) to review. -New medication orders not included in the current MDP cycle, were packaged in bubble packs. -MAs were responsible for contacting the pharmacy if the bubble pack was not received and leaving a note for her to follow up. Telephone interview with Resident #5's primary care provider (PCP) on 01/24/24 at 11:27am revealed: -The MHP treated Resident #5 for mental health conditions. -No aggressive or abusive behaviors had been reported to her by staff since 01/13/24. Telephone interview with Resident #5's MHP's Office Manager on 01/24/24 at 1:51pm revealed: -The MHP was notified on 01/23/24 about Resident #4's divalproex 250mg ER and 500mg ER not being dispensed from the pharmacy. -Divalproex was ordered to treat Resident #5's mood. -The order was changed by the hospital on 01/13/24. -The new order was not the same form as what the MHP ordered. -The capsules allowed for sprinkles to be mixed in with food where the new form was extended-release tablets. -There were existing issues with Resident #5 taking his medications; he refused medications frequently. -Not receiving the divalproex for 8 days could contribute to aggressive behavior.	D 358		

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-It was difficult to determine the effect of medications on Resident #5's behavior due to frequent refusals and sporadic behavior episodes.
-No behavioral episodes had been reported by staff since 01/13/24.

Refer to interview with a medication aide (MA) on 01/25/24 at 11:55am.

Refer to interview with the Resident Care Coordinator (RCC) on 01/24/24 at 5:07pm.

Refer to interview with the Administrator on 01/24/24 at 5:00pm.

b. Review of Resident #5's current FL-2 dated 01/17/24 revealed an order for paroxetine 30mg daily. (Paroxetine is an antidepressant used to treat depression.)

Review of Resident #5's prescription order dated 01/15/24 revealed an order for paroxetine 20mg daily.

Review of Resident #5's January 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for paroxetine 20mg daily at 8:00am dated 01/18/24 - open.
-There was documentation paroxetine 20mg was administered daily from 01/18/24 - 01/23/24 except on 01/20/24 when the dose was refused.

Observation of Resident #5's medications on hand on 01/23/24 at 3:53pm revealed there was no paroxetine on hand for Resident #5.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/23/24 at

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D 358	Continued From page 20 4:00pm revealed: -The pharmacy had a record of a current order dated 01/15/24 for paroxetine 20mg daily for Resident #5. -The previous order for paroxetine 30mg daily was discontinued on 01/15/24. -The pharmacy billed and dispensed medications in 7 day cycles. -The new order for paroxetine dated 01/15/24 was not billed or dispensed for Resident #5. -The first billing was scheduled for 01/24/24 for a start date of 01/26/24. -She did not know why paroxetine 20mg was not dispensed for Resident #5. -She did not see a record of staff contacting the pharmacy about Resident #5's paroxetine ordered on 01/15/24. Interview with a medication aide (MA) on 01/24/24 at 2:53pm revealed: -He always checked the multidose pack (MDP) contents against the eMAR prior to administering medications. -If a medication was not administered, he documented the medication was not administered and the reason on the eMAR. -He did not know why he documented administering paroxetine 20mg at 8:00am on 01/18/24 - 01/23/24 (except refusal on 01/20/24) when it was not in the MDP. -He should have documented Resident #5 refused or that the medication was not in the building. Second interview with the MA on 01/25/24 at 11:55am revealed: -Resident #4's new medication orders (01/15/24) were written on the board in the medication room. -He thought MAs did follow up on Resident #4's paroxetine.	D 358		

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-He did not know about the new order for divalproex and paroxetine because he was off from work for a few days.
-He noted the changed orders to the paroxetine when he returned to work and brought it to the Resident Care Coordinator's (RCC's) attention.
-The RCC was already aware and had ordered the medication from the pharmacy.

Telephone interview with Resident #5's Mental Health Provider's (MHP's) Office Manager on 01/24/24 at 1:51pm revealed:
-The MHP was notified on 01/23/24 about Resident #4's paroxetine 20mg not being dispensed from the pharmacy.
-Paroxetine was ordered to decrease Resident #5's libido and decrease sexually inappropriate behaviors.
-The order was decreased by the hospital on 01/13/24; he was previously on 30mg daily.

Interview with the RCC on 01/25/24 at 3:12pm revealed:
-She and the Administrator were responsible for reviewing medication cart audit forms and any notes documented by the MA for follow up.
-Once the medication cart audit forms were reviewed, they were discarded so there was no record of completed medication cart audits for January 2024 for Resident #5.
-A medication cart audit was not done for Resident #5 when the divalproex and paroxetine were not on the medication cart.

Interview with the Administrator on 01/25/24 at 3:43pm revealed:
-MAs were responsible for notifying her and the RCC when there was an issue with medication availability.
-It was important to have medications in the

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D 358	Continued From page 22 building to administer as ordered by the provider. Refer to interview with a medication aide (MA) on 01/25/24 at 11:55am. Refer to interview with the Resident Care Coordinator (RCC) on 01/24/24 at 5:07pm. Refer to interview with the Administrator on 01/24/24 at 5:00pm. _____ Interview with a medication aide (MA) on 01/25/24 at 11:55am revealed: -All new orders were given to the Resident Care Coordinator (RCC) who wrote the new orders on the board in the medication room for MAs to follow up on. -MAs followed up on new medication orders by making sure the new medication was in the building. -MAs were supposed to contact the pharmacy to check on the status of any new medication not in the building. -MAs were responsible to complete medication cart audits for 3 rooms every shift. -There was a calendar style assignment with 3 rooms assigned to each shift. -MAs were responsible to compare medications on hand to the physician's order sheet and verify all medications were in the building. -Refill requests were sent to the pharmacy for medications not contained in multidose packs (MDPs). -The pharmacy made deliveries every day except Sundays and MDPs were delivered weekly. Interview with the Resident Care Coordinator (RCC) on 01/24/24 at 5:07pm revealed: -They had a bucket system process with colored folders to manage orders.	D 358		

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D 358	Continued From page 23 -She wrote new medication orders on the bulletin board in the medication room so all staff were aware of any need for follow up. -She faxed new orders to the pharmacy and placed in the yellow folder. -She was responsible for reviewing and approving new orders entered into the electronic medication system by the pharmacy. -Normally, MAs were responsible for making sure new medications were on the cart and they were to notify her if they were not delivered. -Medications needed immediately could be provided by the backup pharmacy. Interview with the Administrator on 01/24/24 at 5:00pm revealed: -Weekly cart audits were done by MAs to ensure medications were on the cart. -MAs notified pharmacy via the electronic medication system of any needed refills. -MAs were responsible for documenting contact with the pharmacy on the electronic medication system. -MAs were responsible for administering medications as ordered by the provider. -She expected MAs to do everything possible to ensure medications were in the facility. -She and the RCC were responsible for reviewing documentation on the facility activity report every morning. _____ The facility failed to administer a long-acting insulin and sliding scale insulin to Resident #4 who had a finger stick blood sugar result of 439 on 01/12/24 and increased finger stick blood sugar results from as high as 275 in November 2023, to a high of 337 in December 2023 to as high as 439 for January 2024; and mood stabilizing and antidepressant medications to Resident #5 who had a history of physical and	D 358		

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D 358	Continued From page 24 verbal aggression and was recently discharged from the hospital with a diagnosis of suicidal ideation and homicidal behavior which resulted in substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/24/24 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 24, 2024.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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D 367	Continued From page 25 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to accurately document medication administration for 2 of 7 sampled residents (#4 and #5) including long-acting insulin (#4), and mood stabilizing and antidepressant medications (#5). The findings are: Review of the facility's Medication Services/Pharmaceutical Care Services Policy and Procedures dated September 2021 revealed all medications that staff members handle, store, and administer were documented on the medication administration record (MAR) in accordance with state regulations. 1. Review of Resident #4's current FL-2 dated 01/17/24 revealed diagnoses included type II diabetes mellitus, schizophrenia, hyperlipidemia, hypertension, peripheral nervous system disorder, cervical spine stenosis and left 2nd toe amputation. Review of Resident #4's FL-2 dated 01/17/24 revealed an order for Levemir 40 units twice daily (Levemir is a long-acting insulin used to control blood sugar levels). Review of Resident #4's prescription order dated 01/18/24 revealed: -There was an order to discontinue Levemir for insurance preference. -There was an order for Lantus 40 units twice daily. Review of Resident #4's January 2024 eMAR revealed:	D 367		

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D 367	Continued From page 26 -There was an entry for Levemir 40 units twice daily at 8:00am and 8:00pm dated 05/01/23 - 01/11/24. -There was documentation Levemir was administered twice daily 01/01/24 through 01/10/24 and at 8:00am on 01/11/24. -There was a second entry for Levemir 40 units twice daily at 8:00am and 8:00pm dated 01/11/24 - 01/18/24. -There was documentation Levemir was administered at 8:00pm on 01/11/24, twice daily 01/12/24 - 01/17/24, and at 8:00am on 01/18/24. -There was a third entry for Levemir 40 units twice daily at 8:00am and 8:00pm dated 01/18/24 - 01/20/24. -There was documentation Levemir was administered at 8:00pm on 01/18/24, 8:00am and 8:00pm on 01/19/24, and at 8:00pm on 01/20/24. -There was an entry for Lantus 40 units twice daily at 8:00am and 8:00pm dated 01/19/24 - open. -There was documentation Lantus was administered at 8:00pm on 01/19/24, 8:00am and 8:00pm on 01/20/24 - 01/22/24, and at 8:00am on 01/23/24. -There was documentation that Levemir and Lantus were administered at 8:00pm on 01/19/24 and 01/20/24. Observation of Resident #4's medications on hand on 01/24/24 at 2:53pm revealed there was no Levemir or Lantus on hand for Resident #4. Interview with a medication aide (MA) on 01/25/24 at 3:04pm revealed: -Resident #4's Levemir pen was empty on 1/19/24 when she got ready to administer it. -She saw that he didn't have any and when she called the pharmacy that evening to see why they had not sent the pen, they said that the	D 367		

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manufacturer discontinued it.
-She told the pharmacy that Resident #4 was supposed to get 40 units of Levemir and asked what were they going to do.
-The pharmacy told her that everyone on Levemir would be changed to Lantus so she documented on the eMAR that she had given Resident #4 the Levemir but he actually got the Lantus.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/24/24 at 3:53pm revealed:
-The original order from May 2023 was for Levemir 40 units twice daily.
-The pharmacy dispensed 15ml or 1500 units of Levemir in 5 pens with 300 units per pen which was an 18-day supply on 11/07/23, 11/27/23 and 12/19/23 for Resident #4.
-The manufacturer discontinued Levemir so there was none dispensed after 12/19/23.

Second telephone interview with a pharmacist from the facility's contracted pharmacy on 01/24/24 at 4:28pm revealed:
-Due to Levemir being discontinued by the manufacturer a new long-acting insulin order was needed for Resident #4.
-The order was written specifically for Lantus and not inclusive of generic versions and the brand was not covered by Resident #4's insurance.
-A prior authorization form for Resident #4's Lantus was faxed to the PCP's office on 01/18/24.
-An "Unable to Fill Notification" for Resident #4's Lantus was faxed to the facility on 01/18/24 and 01/19/24.
-The pharmacy did not dispense any Lantus for Resident #4.

Interview with a medication aide (MA) on

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D 367	Continued From page 28 01/25/24 at 11:55am revealed: -Resident #4 had extra Levemir pens when the pharmacy dispensed his Levemir pens in December 2023; he did not know how many extra pens. -Resident #4 did not run out of Levemir. -Resident #4 did not receive Levemir and Lantus on the same day; the Lantus was started because Levemir was discontinued. Third telephone interview with a pharmacist from the facility's contracted pharmacy on 01/25/24 at 12:41pm revealed: -The pharmacy entered provider orders on the electronic medication system on their side, but the facility had the ability to enter and stop orders on their side of the system. -Normally, refilled and new orders would trigger a new pharmacy entry on the eMAR. -The pharmacy did not dispense any Levemir for Resident #4 in January 2024 so the pharmacy would not have made a new entry for Levemir on the MAR. -She could not see the two additional entries (01/11/24 and 01/18/24) for Levemir on the pharmacy side of the electronic medication system. -The additionally entries may have been done on the facility side of the electronic medication system. Fourth telephone interview with a pharmacist from the facility's contracted pharmacy on 01/25/24 at 2:58pm revealed: -At 80 units total per day and 300 units per pen, one Levemir or Lantus (equal) pen would last Resident #4 3.75 days. -One pen might last 4 days because there was a little extra insulin in each pen.	D 367		

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D 367	Continued From page 29 Based on Resident #4's pharmacy dispensing history for Levemir and telephone interview with the pharmacist, Levemir dispensed on 11/07/23 would have lasted 18 days or until 11/25/23, Levemir dispensed on 11/27/23 would have lasted 18 days or until 12/15/23, and Levemir dispensed on 12/19/23 would have lasted 18 days or until 01/06/24. Interview with the Resident Care Coordinator (RCC) on 01/25/24 at 3:12pm revealed there was no Levemir in the facility on 01/20/24, so the documentation that Levemir was administered to Resident #4 at 8:00pm on 01/19/24 and 01/20/24 was a documentation error. Interview with the Administrator on 01/25/24 at 3:43pm revealed: -She did not know of Resident #4 running out of insulin prior to 01/23/24. -She did not know both Lantus and Levemir were documented as administered to Resident #4 on 01/19/24 and 01/20/24. -She and the RCC reviewed eMAR documentation on the facility activity report daily. -She did not see that there was documentation that both Levemir and Lantus were administered on 01/19/24 and 01/20/24. 2. . Review of Resident #5's current FL-2 dated 01/17/24 revealed diagnoses included cerebral vascular accident, convulsions, and behaviors. a. Review of Resident #5's current FL-2 dated 01/17/24 revealed an order for divalproex 125mg 4 capsules daily at noon. (Divalproex is used to stabilize mood disorders.) Review of Resident #5's emergency room discharge instructions dated 01/13/24 revealed:	D 367		

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-Resident #5 was seen for suicidal and homicidal behavior.
-There were instructions to start divalproex 250mg extended release (ER) daily and divalproex 500mg ER daily at bedtime.

Review of Resident #5's prescription orders dated 01/15/24 revealed divalproex 250mg ER daily and divalproex 500mg ER daily at bedtime.

Review of Resident #5's January 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for divalproex 250mg ER daily at 8:00am dated 01/18/24 to "open".
-There was documentation divalproex 250mg ER was administered daily from 01/18/24 to 01/23/24 except on 01/20/24 when the dose was refused.
-There was an entry for divalproex 500mg ER daily at 8:00pm dated 01/17/24 to "open".
-There was documentation divalproex 500mg ER was administered daily at bedtime 01/18/24 to 01/21/24 except on 01/20/24 when the dose was refused.
-There was documentation divalproex 500mg ER was refused on 01/17/24 and 01/22/24.

Observation of Resident #5's medications on hand on 01/23/24 at 3:53pm revealed there was no divalproex on hand for Resident #5.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/23/24 at 4:00pm revealed:
-The pharmacy had a record of a current order dated 01/15/24 for divalproex 250mg extended release (ER) every morning and 500mg ER every evening for Resident #5.
-The previous order for divalproex 125mg 4 capsules was discontinued on 01/15/24.

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-The pharmacy billed and dispensed medications in 7-day cycles.
-The new orders for divalproex dated 01/15/24 were not billed or dispensed for Resident #5.
-The first billing was scheduled for 01/24/24 for a start date of 01/26/24.
-She did not know why divalproex 250mg ER and 500mg ER were not dispensed for Resident #5.
-She did not see a record of staff contacting the pharmacy about Resident #5's divalproex ordered on 01/15/24.

Interview with a medication aide (MA) on 01/23/24 at 4:17pm revealed:
-Normally, she clicked on each medication listed on the eMAR when she prepared medications for administration.
-She did not scan the barcode on the multidose pack (MDP).
-She documented administering divalproex 500mg ER at 8:00pm on 01/19/24 and 01/21/24 to Resident #5.
-She did not remember giving Resident #5 divalproex.
-She was used to administering 2 medications at 8:00pm to Resident #5.
-She did not know there was a new order for divalproex every evening.

Interview with the Resident Care Coordinator (RCC) on 01/23/24 at 4:23pm revealed:
-She did not think Resident #5 went without doses of divalproex because he had some of the capsules from the previous order still in the facility.
-She did not realize the dosage and form were different (capsules with sprinkle verses extended release and 125mg verses 250mg and 500mg).

b. Review of Resident #5's current FL-2 dated

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D 367	Continued From page 32 01/17/24 revealed an order for paroxetine 30mg daily. (Paroxetine is an antidepressant used to treat depression.) Review of Resident #5's prescription order dated 01/15/24 revealed an order for paroxetine 20mg daily. Review of Resident #5's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for paroxetine 20mg daily at 8:00am dated 01/18/24 to "open". -There was documentation paroxetine 20mg was administered daily from 01/18/24 to 01/23/24 except on 01/20/24 when the dose was refused. Observation of Resident #5's medications on hand on 01/23/24 at 3:53pm revealed there was no paroxetine on hand for Resident #5. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/23/24 at 4:00pm revealed: -The pharmacy had a record of a current order dated 01/15/24 for paroxetine 20mg daily for Resident #5. -The previous order for paroxetine 30mg daily was discontinued on 01/15/24. -The pharmacy billed and dispensed medications in 7 day cycles. -The new order for paroxetine dated 01/15/24 was not billed or dispensed for Resident #5. -The first billing was scheduled for 01/24/24 for a start date of 01/26/24. -She did not know why paroxetine 20mg was not dispensed for Resident #5. -She did not see a record of staff contacting the pharmacy about Resident #5's paroxetine ordered on 01/15/24.	D 367		

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D 367	Continued From page 33 Interview with a medication aide (MA) on 01/24/24 at 2:53pm revealed: -He always checked the multidose pack (MDP) contents against the eMAR prior to administering medications. -If a medication was not administered, he documented the medication was not administered and the reason on the eMAR. -He did not know why he documented administering paroxetine 20mg at 8:00am on 01/18/24 - 01/23/24 (except refusal on 01/20/24) when it was not in the MDP. -He should have documented Resident #5 refused or rather the medication was not in the building. Interview with the Administrator on 01/25/24 at 3:43pm revealed: -Medications not administered should be documented as not administered on the eMAR by the MA. -MAs were responsible for documenting why medications were not given and what was done about any issues related to the medication not being administered. -Documentation on the eMAR showed up on the facility activity report so she and the RCC would see medications issues and know to follow up.	D 367		
D 372	10A NCAC 13F .1004 (o) Medication Administration 10A NCAC 13F .1004 Medication Administration (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly	D 372		

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and the borrowing and replacement of the medication shall be documented.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure a borrowed long-acting insulin pen involving 3 residents (#4, #10 and #11) was used in an emergency, documented and replaced promptly.

The findings are:

Review of the facility's Medication Services/Pharmaceutical Care Services Policy and Procedures dated September 2021 revealed:
-Administration of any medication order specified by the prescriber as "emergency" or "STAT" shall be started within 2 hours of said order.
-Borrowing of another resident's medications shall be allowed if absolutely necessary to meet criteria outlined above for STAT, or urgent antibiotic orders.
-Appropriate record should be made and attached to the resident's MAR from whom the doses were borrowed in order to facilitate "payback" of such borrowed doses.

1. Review of Resident #11's current FL-2 dated 06/01/23 revealed:
-Diagnoses included type II diabetes mellitus with complications.
-There was an order for Lantus 12 units every morning.

Observation of medications on hand for Resident #11 on 01/25/24 at 11:52am revealed:
-There were 3 unopened Lantus pens in a plastic bag in the medication refrigerator.
-There was a pharmacy label with Resident #11's name indicating 15ml of Lantus was dispensed

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D 372	Continued From page 35 on 12/18/23. -There was one Lantus pen in the medication cart drawer with an open date of 01/01/24 and a pharmacy label with Resident #11's name. Review of Resident #11's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus 12 units every morning. -There was documentation Lantus was administered daily from 01/01/24 through 01/24/24. Interviews with a medication aide (MA) on 01/24/24 at 5:37pm and 6:57pm revealed: -She previously identified the wrong resident she borrowed Lantus from for Resident #4. -She borrowed the Lantus from Resident #11 for Resident #4 because Resident #11 was the only resident who had Lantus. -She did not borrow Levemir because it was discontinued by the manufacturer. -She borrowed one whole pen of Lantus from Resident #11 for Resident #4. -She used the entire contents of the borrowed Lantus pen for Resident #4. -She was concerned with making sure Resident #4 received his Lantus because he needed 40 units of Lantus twice daily. -The facility had a form MAs were supposed to fill out when borrowing medications, but she did not complete the form. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/25/24 at 12:41pm revealed: -The pharmacy had a current order dated 08/14/23 for Lantus 12 units every morning for Resident #11.	D 372		

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-She only saw Lantus being dispensed once for Resident #11.
-The pharmacy dispensed 15ml or 5 pens of 300 units each of Lantus for Resident #11 on 12/18/23.

2. Review of Resident #4's current FL-2 dated 01/17/24 revealed diagnoses included type II diabetes mellitus, schizophrenia, hyperlipidemia, hypertension, peripheral nervous system disorder, cervical spine stenosis and left 2nd toe amputation.

Review of Resident #4's FL-2 dated 01/17/24 revealed an order for Levemir 40 units twice daily.

Review of Resident #4's prescription order dated 01/18/24 revealed:
-There was an order to discontinue Levemir for insurance preference.
-There was an order for Lantus 40 units twice daily.

Review of Resident #4's physician's order dated 01/24/24 revealed:
-There was documentation of notification to Resident #4's primary care provider (PCP) that Resident #4 did not have Levemir or Lantus insulin in the facility.
-There was a telephone order from the PCP to check Resident #4's FSBS level and give Novolog SSI according to the FSBS result.

Review of Resident #4's January 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Levemir 40 units twice daily at 8:00am and 8:00pm dated 05/01/23 to 01/11/24.
-There was documentation Levemir was

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administered twice daily from 01/01/24 to 01/10/24 and at 8:00am on 01/11/24.
-There was a second entry for Levemir 40 units twice daily at 8:00am and 8:00pm dated 01/11/24 to 01/18/24.
-There was documentation Levemir was administered at 8:00pm on 01/11/24, twice daily 01/12/24 to 01/17/24, and at 8:00am on 01/18/24.
-There was a third entry for Levemir 40 units twice daily at 8:00am and 8:00pm dated 01/18/24 to 01/20/24.
-There was documentation Levemir was administered at 8:00pm on 01/18/24, 8:00am and 8:00pm on 01/19/24, and at 8:00pm on 01/20/24.
-There was an entry for Lantus 40 units twice daily at 8:00am and 8:00pm dated 01/19/24 to "open".
-There was documentation Lantus was administered at 8:00pm on 01/19/24, 8:00am and 8:00pm on 01/20/24 to 01/22/24, and at 8:00am on 01/23/24.

Observation of Resident #4's medications on hand on 01/24/24 at 2:53pm revealed there was no Levemir or Lantus on hand for Resident #4.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/24/24 at 3:53pm revealed:
-The original order from May 2023 was for Levemir 40 units twice daily.
-The pharmacy dispensed 15ml or 1500 units of Levemir in 5 pens with 300 units per pen which was an 18-day supply on 11/07/23, 11/27/23 and 12/19/23 for Resident #4.
-The manufacturer discontinued Levemir so there was none dispensed after 12/19/23.

Second telephone interview with a pharmacist from the facility's contracted pharmacy on

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01/24/24 at 4:28pm revealed:
-Due to Levemir being discontinued by the manufacturer a new long-acting insulin order was needed for Resident #4.
-The order was written specifically for Lantus and not inclusive of generic versions and the brand was not covered by Resident #4's insurance.
-A prior authorization form for Resident #4's Lantus was faxed to the PCP's office on 01/18/24.
-An "Unable to Fill Notification" for Resident #4's Lantus was faxed to the facility on 01/18/24 and 01/19/24.
-The pharmacy did not dispense any Lantus for Resident #4.

Third telephone interview with a pharmacist from the facility's contracted pharmacy on 01/25/24 at 2:58pm revealed:
-At 80 units total per day and 300 units per pen, one Levemir or Lantus (equal) pen would last Resident #4 3.75 days.
-One pen might last 4 days because there was a little extra insulin in each pen.

Interview with a medication aide (MA) on 01/25/24 at 11:55am revealed:
-He was not aware of insulin pens being borrowed for Resident #4.
-He did not know where the Lantus insulin pen came from for Resident #4.
-When he came in to work on 01/19/24 to 01/23/24, the Lantus pen was already in the medication cart drawer for Resident #4.
-MAs could borrow any medication from a resident for another resident except controlled substances.
-MAs were supposed to document what was borrowed, how much was borrowed and from which resident the medication was borrowed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078100	A. BUILDING: _____ B. WING _____	R 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE SPRINGS	104 HOPE LANE RED SPRINGS, NC 28377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 372	Continued From page 39	D 372		

from.
-MAs were supposed to sign and date the form and give the form to the Resident Care Coordinator (RCC).

Interview with the Resident Care Coordinator (RCC) on 01/24/24 at 5:07pm revealed:
-There were 2 extra Lantus pens from a current resident in the facility that were used for Resident #4.
-MAs were responsible for completing a medication borrowed form and giving the completed form to her.
-She did not get a completed medication borrowed form for the Lantus borrowed for Resident #4.

Interview with the RCC on 01/25/24 at 3:12pm revealed:
-She knew of one Lantus pen being borrowed from a resident for Resident #4.
-The MA told her they thought Resident #4 not having any Lantus of his own was an emergency situation.
-That was why the MA borrowed one whole Lantus pen from Resident #11 for Resident #4.
-The MA should have contacted the PCP and documented borrowing the medication on the designated form.

Interview with the Administrator on 01/25/24 at 3:43pm revealed:
-She knew of only one Lantus pen being borrowed for Resident #4.
-MAs should have contacted Resident #4's PCP for clarification on what to do when he ran out of his long-acting insulin.
-MAs were responsible to document contact with the PCP in the resident's electronic progress notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078100	A. BUILDING: _____ B. WING _____	R 01/25/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 372	Continued From page 40 -MAs were responsible for notifying her and the RCC when there was an issue with medication availability. -MAs should have completed a medication borrowed form for the borrowed Lantus pen. -MAs should have made her and the RCC aware the Lantus was borrowed to ensure replacement and follow up on Resident #4's insulin.	D 372		