

Division of Health Service Regulation
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL078082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/12/2024
NAME OF PROVIDER OR SUPPLIER CROMARTIE SPRING VILLAGE REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 508 WORTH STREET SAINT PAULS, NC 28384		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 1</p> <p>medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry to check FSBS twice daily with Novolog SSI as follows: for FSBS 200-250 give 5 units, 251-300 give 10 units, 301-350 give 15 units, 351-400 give 20 units, and greater than 400 call the PCP. -On 03/03/24 at 7:00pm the FSBS was 228 and there was documentation 10 units of SSI was administered instead of 5 units. -On 03/11/24 at 7:00pm the FSBS was 331 and there was documentation no SSI was administered instead of 15 units. -There were 62 FSBS results ranging from 61 to 331 and 4 opportunities to administer SSI for FSBS results between 200 and 400 with 2 SSI errors. <p>Review of Resident #3's April 2024 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry to check FSBS twice daily with Novolog SSI as follows: for FSBS 200-250 give 5 units, 251-300 give 10 units, 301-350 give 15 units, 351-400 give 20 units, and greater than 400 call the PCP. -On 04/01/24 at 7:00pm the FSBS was 207 and there was documentation no SSI was administered instead of 5 units. -On 04/02/24 at 7:00pm the FSBS was 256 and there was documentation no SSI was administered instead of 10 units. -There were 23 FSBS results ranging from 84 to 258 and 3 opportunities to administer SSI for FSBS results between 200 and 400 with 2 SSI errors. <p>Observation of Resident #3's medications on hand on 04/12/24 at 1:39pm revealed:</p> <ul style="list-style-type: none"> -There was a Novolog insulin pen in Resident #3 medication bin inside the medication cart drawer. 	D 358		

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NAME OF PROVIDER OR SUPPLIER
CROMARTIE SPRING VILLAGE REST HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**508 WORTH STREET
SAINT PAULS, NC 28384**

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D 358	<p>Continued From page 2</p> <p>-There was a handwritten date of "02/21/24" with the resident's initials on the Novolog insulin pen. -The manufacturer's expiration date on Resident #3's Novolog insulin pen was 12/31/2023. -There was a manufacturer's box of Novolog insulin with a pharmacy label and Resident #3's name from the medication storage in the refrigerator.</p> <p>-There were 3 unopened Novolog insulin pens with a manufacturer's expiration date of 05/31/24.</p> <p>Interview with the Resident Care Coordinator (RCC) on 04/12/24 at 1:50pm revealed:</p> <p>-She administered medications to residents. - Resident #3 did not use the Novolog Insulin often. -Novolog insulin was administered to Resident #3 when his blood sugar was greater than 200. - She could not say why SSI was not administered on 04/01/24 and 04/02/24.</p> <p>Interview with the Administrator on 04/12/24 at 4:13pm revealed:</p> <p>-If Resident #3's blood sugar level was more 200 the SSI amount should have been 5 units. - Resident #3's eMAR showed that some of the SSI administered was the incorrect number of units. -The RCC and medication aides (MAs) were responsible for checking the eMAR to ensure the correct number of SSI units were being administered to Resident #3. -The RCC and MAs were trained and certified to administer medications and document administration of medications.</p> <p>Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 04/12/24 at 12:56pm was unsuccessful.</p>	D 358		

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D 371 D 371	<p>Continued From page 3</p> <p>10A NCAC 13F .1004(n) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.</p> <p>This Rule is not met as evidenced by: Based on observations, Interviews and record reviews, the facility failed to ensure sliding scale insulin administered to 1 of 1 sampled resident (#3) was replaced 28 days after opening and prior to manufacturer's expiration date to prevent contamination and ensure effectiveness.</p> <p>The findings are:</p> <p>Review of Resident #3's current FL-2 dated 01/21/24 revealed: -Diagnoses included reactive type II diabetes mellitus, schizophrenia, and hypertension. - There was an order to check finger stick blood sugar (FSBS) twice daily with Novolog sliding scale insulin (SSI) as follows: for FSBS 200-250 give 5 units, 251-300 give 10 units, 301-350 give 15 units, 351-400 give 20 units, and greater than 400 call the primary care provider (PCP). (Novolog is a rapid acting insulin used to control blood glucose levels.)</p> <p>Review of Resident #3's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS twice daily with Novolog SSI as follows: for FSBS 200-250</p>	D 371 D 371	<p>10A NCAC 13F .1004 Medication Administration reply Current Infection Control Policy will be reviewed quarterly by administrator with input from infection consultant RN [REDACTED] and updated as needed. Staff will receive quarterly infection control training to ensure a minimum 3 hours of infection control training annually.</p> <p>May 8, 2024 Professional In-service training ("Highs and lows of diabetes and medication administration of diabetes" provided by Resident Pharmacist [REDACTED])</p> <ul style="list-style-type: none"> Required training for all staff with 4 staff members attending, attendance and certification attached to each staff member's personnel folder. <p>All blood sugar readings, meters, insulin decanters and other diabetic supplies will be monitored weekly for cleanliness and date expiration by administrator.</p> <p>Standing patient orders are monitored weekly by administrator for compliance, with special focus on sliding scale insulin.</p> <p>Blood sugar reading >400 will prompt immediate contact of Primary Care Physician [REDACTED]</p>	

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D 371	<p>Continued From page 4</p> <p>give 5 units, 251-300 give 10 units, 301-350 give 15 units, 351-400 give 20 units, and greater than 400 call the PCP.</p> <p>-There were 62 FSBS results ranging from 61 to 331 and documentation Novolog SSI was administered for 3 FSBS results between 200 and 400.</p> <p>-On 03/03/24 at 7:00pm the FSBS was 228 and there was documentation 10 units of Novolog SSI was administered.</p> <p>-On 03/26/24 at 7:00pm the FSBS was 217 and there was documentation 5 units of Novolog SSI was administered.</p> <p>-On 03/29/24 at 7:00pm the FSBS was 258 and there was documentation 10 units of Novolog SSI was administered.</p> <p>Review of Resident #3's April 2024 eMAR revealed:</p> <p>-There was an entry to check FSBS twice daily with Novolog SSI as follows: for FSBS 200-250 give 5 units, 251-300 give 10 units, 301-350 give 15 units, 351-400 give 20 units, and greater than 400 call the PCP.</p> <p>-There were 23 FSBS results ranging from 84 to 258 and documentation Novolog SSI was administered for 1 FSBS result between 200 and 400.</p> <p>-On 04/05/24 at 7:00pm the FSBS was 202 and there was documentation 5 units of Novolog SSI was administered.</p> <p>Observation of Resident #3's medications on hand on 04/12/24 at 1:39pm revealed:</p> <p>-There was a Novolog insulin pen in Resident #3 medication bin inside the medication cart drawer. - There was a handwritten date of "02/21/24" with the resident's initials on the Novolog insulin pen. -The manufacturer's expiration date on Resident #3's Novolog insulin pen was 12/31/2023.</p>	D 371		

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SAINT PAULS, NC 28384

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D 371	<p>Continued From page 5</p> <p>-There was a manufacturer's box of Novolog insulin with a pharmacy label and Resident #3's name from the medication storage in the refrigerator.</p> <p>-There were 3 unopened Novolog insulin pens with a manufacturer's expiration date of 05/31/24.</p> <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/12/24 at 4:07pm revealed:</p> <p>-Novolog insulin was only good for 28 days when stored outside of the refrigerator.</p> <p>-Novolog insulin that was expired by the manufacturer's date and/or stored outside the refrigerator more than 28 days had the potential to grow bacteria and not be as effective in regulating blood sugar levels.</p> <p>Interview with the Resident Care Coordinator (RCC) on 04/12/24 at 1:50pm revealed:</p> <p>-She administered medications to residents. - Resident #3 did not use the Novolog insulin often.</p> <p>-Novolog insulin was kept on the medication cart until it expired based on the manufacturer's expiration date.</p> <p>-She did not notice the open date and expiration date on Resident #3's Novolog Insulin pen because she had not administered Novolog Insulin to the resident.</p> <p>-Novolog insulin was administered to Resident #3 when his blood sugar was greater than 200.</p> <p>Interview with the Administrator on 04/12/24 at 4:13pm revealed:</p> <p>-The medication aide (MA) who opened the insulin pen was responsible for writing the open date on the insulin pen.</p> <p>-MAs were responsible for checking the open date on the insulin pen prior to administering</p>	D 371		

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D 371	Continued From page 6 Insulin from the pen. -Normally insulin pens were not stored outside the refrigerator for more than 28 days because Resident #3 used the insulin within the 28 days. - He administered Novolog SSI Insulin to Resident #3 on 04/05/24. -He did not think he checked Resident #3's Novolog insulin pen for the open date and expiration date prior to administering the Novolog on 04/05/24. -He, the RCC and MAs were trained annually on infection prevention and control and insulin administration. Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 04/12/24 at 12:56pm was unsuccessful.	D 371		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 2 of 3 sampled residents (#1 and #3) with orders for controlled substances to treat pain (#1) and anxiety (#3). The findings are:	D 392	10A NCAC 13F .1008 (a) Controlled Substances, reply Quarterly In-service training will be provided to staff on Medication Administration with special focus on administration of Controlled Substances to include storage, distribution, and administration of controlled substances .SIC XXXXXX will weekly monitor CDR to ensure alignment with EMAR and actual drug count. Administrator and SIC will conduct a daily review of patient records to ensure alignment of patient record, EMAR and CDR and actual count.	

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D 392	<p>Continued From page 7</p> <p>1. Review of Resident #1's current FL-2 dated 04/08/24 revealed diagnoses included alcohol dependence, muscle weakness, and hypertension.</p> <p>Review of Resident #1's current physician orders dated 04/07/24 revealed there was an order for Tramadol 50mg three times daily (Tramadol is used to treat pain).</p> <p>Review of Resident #1's March 2024 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for Tramadol 50mg three times daily at 8:00am, 12:00pm, and 8:00pm. - Tramadol was documented as administered on 03/28/24-03/31/24 at 8:00am, 03/28/24- 03/29/24 and 03/31/24 at 12:00pm and 03/28/24-03/31/24 at 8:00pm. -There was an exception documented on 03/30/24 at 12:00pm that Resident #1 refused the Tramadol. -There was a total of 11 Tramadol tablets administered from 03/28/24 to 03/31/24. - There was no documentation on the eMAR for 03/26/24 and 03/27/24. <p>Review of Resident #1's April 2024 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for Tramadol 50mg three times daily at 8:00am, 12:00pm, and 8:00pm. - Tramadol was documented as administered on 04/01/24-04/12/24 at 8:00am, 04/01/24-04/11/24 at 12:00pm, and 04/01/24-04/11/24 at 8:00pm. - There was a total of 34 Tramadol tablets administered and 1 Tramadol tablet administered on 04/12/24 at 12pm after the eMAR was printed. <p>Observation of Resident #1's medications on</p>	D 392		

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D 392	<p>Continued From page 9</p> <ul style="list-style-type: none"> -Tramadol was administered on 04/08/24 at 7:00am and 7:00pm. -Tramadol was administered on 04/09/24 at 7:00am and 7:00pm. -Tramadol was administered on 04/10/24 at 7:00am and 7:00pm. -Tramadol was administered on 04/11/24 at 7:00am and 7:00pm. -Tramadol was administered on 04/12/24 at 7:00am and 12:00pm. -The CDR had a place to handwrite/document the full signature of the person administering the medication, date, time, amount given, and amount remaining. -The CDR was not completed as required with the full signature of the person administering the medication, date, time, amount given, and amount remaining. -There were 40 Tramadol tablets documented as administered from 03/26/24 to 04/12/24. - -There were 45 tablets of Tramadol 50mg remaining. <p>Telephone interview with the facility's contracted pharmacy technician on 04/12/24 at 4:35pm revealed:</p> <ul style="list-style-type: none"> -Tramadol 50mg was dispensed for Resident #1 on 03/25/24 for 90 tablets (3 medication cards of 30 each). -The controlled drug record (CDR) was sent with the Tramadol 50mg. -A medication aide (MA) signed for receipt of medications on 03/25/24. -The pharmacy entered the medication orders onto the eMARs and then it was sent to the facility, and they accepted or declined the eMAR as correct and the pharmacy was notified once this has been completed by the facility. <p>Interview with the Resident Care Coordinator</p>	D 392		

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D 392	<p>Continued From page 10</p> <p>(RCC) on 04/12/24 at 3:05pm revealed: - Resident #1 was administered his Tramadol 3 times daily. -She counted the narcotics when another MA came to work, one MA counted the medication while the other MA reviewed the CDR. -She reviewed the eMAR with the medications before administering medications to the residents. -She was not sure why the CDR did not include all the times Tramadol was administered. -She had been educated on how to complete the CDR by the facility's contracted pharmacy.</p> <p>Interview with the Administrator on 04/12/24 at 3:50pm revealed: -He was responsible for making sure the CDR was completed correctly. -The CDR should have been completed once the Tramadol was administered. -The facility's contracted pharmacy provided education in February 2024 on completing the CDR. -The MAs audited the medication carts twice a month.</p> <p>Attempted telephone interview with the facility's contracted primary care provider (PCP) on 04/12/24 at 12:43pm was unsuccessful.</p> <p>2. Review of Resident #3's current FL-2 dated 01/21/24 revealed: - -Diagnoses included reactive type II diabetes mellitus, schizophrenia, and hypertension. - There was an order for lorazepam 1mg every 6 hours as needed for anxiety/restlessness. (Lorazepam is a controlled substance used to treat anxiety.)</p> <p>Review of Resident #3's controlled drug record</p>	D 392	

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D 392	Continued From page 11	D 392		

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<p>(CDR) dated 03/11/24 revealed: -There was a pharmacy label on the CDR with Resident #3's name and instructions for lorazepam 1mg every 6 hours as needed for anxiety/restlessness. -The pharmacy label indicated 60 lorazepam 1mg tablets were dispensed on 03/11/24. -"2 of 2 = 30" was handwritten below the pharmacy label. -The first entry on the CDR documented 30 tablets were remaining on 03/11/24. -The next entry line on the CDR was blank. - There was documentation on the subsequent entry lines that 25 lorazepam 1mg tablets were removed between 03/29/24 and 04/12/24 with 6 tablets remaining.</p> <p>Review of Resident #3's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 1mg every 6 hours as needed for anxiety/restlessness. - There was documentation 11 doses of lorazepam 1mg were administered between 03/11/24 and 03/29/24.</p> <p>Review of Resident #3's April 2024 eMAR revealed: -There was an entry for lorazepam 1mg every 6 hours as needed for anxiety/restlessness. - There was documentation 4 doses of lorazepam 1mg were administered between 04/03/24 and 03/29/24.</p> <p>Observation of Resident #3's medications on hand on 04/12/24 at 2:07pm revealed: -There was a bubble pack with a pharmacy label that had Resident #3's name and instructions for lorazepam 1mg every 6 hours as needed for anxiety/restlessness.</p>	
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D 392	Continued From page 12 -The pharmacy label indicated 60 tablets were dispensed on 03/11/24 and there were 5 tablets	D 392		

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<p>remaining.</p> <p>Upon request on 04/12/24, Resident #3's CDR documenting 30 of 60 tablets dispensed on 03/11/24 was not provided for review.</p> <p>Interview with the Resident Care Coordinator (RCC) on 04/12/24 at 3:00pm revealed:</p> <ul style="list-style-type: none"> -She removed medications from the medication cart, compared to order entered on the eMAR, administered the medication, and documented the administration on the eMAR and CDR if the medication was a controlled substance. -The first entry on the CDR was from the pharmacy documenting how many tablets were sent. -The CDRs were kept in a binder on the medication cart. -She did not know why the CDR did not match the number of lorazepam tablets remaining for Resident #3. -She must have dropped two tablets instead of one; one yesterday (04/11/24). -She documented the one she dropped today (04/12/24) and thought she had documented any other tablets she might have dropped. -She threw away any dropped tablets. -Sometimes she could not find pills that fell into the medication cart. -She completed an undocumented controlled substance count with the oncoming medication aide (MA) when she was going off duty. -She normally worked in the facility for several days before going off duty. -One MA was responsible for counting the number of pills and the other MA was responsible for verifying the number of pills with the remaining amount on the CDR. 				
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D 392	Continued From page 13 -There were unfiled CDRs and primary care provider (PCP) orders in the Administrator's office somewhere.	D 392		

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	<p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/12/24 at 1:00pm revealed:</p> <ul style="list-style-type: none">-There was an order on Resident #3's physician's orders dated 02/27/24 for lorazepam 1mg every 6 hours as needed for anxiety.-The pharmacy had to call the PCP for clarification on the number of tablets to dispense.-The pharmacy received clarification and dispensed lorazepam for Resident #3 on 03/11/24. <p>Interview with the Administrator on 04/12/24 at 4:13pm revealed:</p> <ul style="list-style-type: none">-He could not answer why there were discrepancies between Resident #3's eMARs and CDRs for lorazepam 1mg.-He relied on the RCC to review CDRs for accuracy. <p>Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 04/12/24 at 12:56pm was unsuccessful.</p>			
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