STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL035-035	A. BUILDING: _____ B. WING _____	R 02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY GROUP HOME #1	663 MOULTON ROAD LOUISBURG, NC 27549

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{V 000}	INITIAL COMMENTS A follow-up survey was completed 2/21/19. A deficiency was cited. This facility is licensed for the following category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	{V 000}		
{V 118}	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	{V 118}		

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{V 118}	Continued From page 1 This Rule is not met as evidenced by: Based on observation, record review and interviews, the governing body failed to assure medications were administered on the written order of a person authorized to prescribe medications for one of three clients (#1). The findings are: Review on 2/21/19 of client #1's record revealed: - admission date 5/6/08 - an FL2 dated 2/12/18 with diagnoses including Moderate Intellectual and Developmental Disabilities and Diabetes- - a nurse practitioner's order dated 11/29/18 for Novolog sliding scale insulin with instructions to administer the following: blood sugar less than 80 = 0 units; 81-100 =2 units; 101-150 = 4 units; 151-200 = 5 units; 201-300 = 7 units; greater than 300 = 8 units twice daily at breakfast and supper Monday through Friday; three times a day at each meal on Saturday and Sunday. Review on 2/12/19 of client #1's diabetic supply box revealed the sliding scale instructions that had been transcribed onto an index card that indicated that if client #1's blood sugar measured between 101 - 150, 3 units of sliding scale insulin should be administered. The rest of the instructions read as on the signed physician's order. Review on 2/14/19 of client #1's blood sugar readings from 1/4/19 to 2/12/19 revealed client	{V 118}		

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{V 118}	Continued From page 2 #1's sliding scale insulin had been administered incorrectly 16 times when her blood sugar measured between 101 - 150; 3 units were administered instead of the prescribed 4 units. During an interview on 2/14/19, the Lead Staff reported she transcribed client #1's order instructions incorrectly onto the index card in the diabetic supply box. During an interview on 2/19/19, staff #1 reported: - she had participated in a diabetes class since the December 2019 survey - client #1's blood sugar was checked twice daily and once prior to bed during the week - she administered client #1's sliding scale insulin according to the directions written on an index card by Lead Staff rather than by the physician's order - she received supervision from Qualified Professional #2 (QP#2) During an interview on 2/19/19, QP#2 reported: - he had participated in an in-service about insulin and diabetes - he went to the facility about once a month to review behavior plans, service plans and other paper work - he provided supervision for staff but not lead staff or supervisors - he check MARs to make sure nothing was left blank but he did not look at medications - he sometimes looked at physician's orders and the blood sugar log sheet - he is getting more familiar with client #1's sliding scale now; he asks the staff if he has questions about the blood sugar log	{V 118}		

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{V 118}	Continued From page 3 During an interview on 2/14/19, the Executive Director/ Qualified Professional #1 (Executive Director) reported: - she offered supervision to assigned staff in the facility - she reviewed documentation once monthly - she checked the MARs to make sure there were no blanks and made sure staff followed up correctly if client #1's blood sugar measured 300 or higher - she had not noted any discrepancies During an interview on 2/19/19, the Registered Nurse (RN) reported she provided updated diabetes training on 12/26/18. The RN reported she had completed one monitoring visit at the facility since the training. The RN reported her focus was on when client #1's blood sugar level measured above 300 to assure staff did an additional blood sugar level check and contacted the physician as needed. The RN reported she did not check the units administered to be sure the sliding scale instructions were followed. Review on 2/21/19 of a Plan of Protection completed 2/21/19 and signed by the Executive Director revealed: What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm? Medications administered in the home will be administered as prescribed by the physician. The RN will implement a system whereby the doctor's order is checked and verified by the pharmacy label and MAR prior to delivery. No other	{V 118}		

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{V 118}	Continued From page 4 administrative process will be acceptable without the RN's authority. Any deviation from this process (i.e.: use of an index card) will be grounds for corrective action as poor job performance. Any non-approved systems (i.e.: index cards) will be removed immediately (2/12/2019). Any updated home diabetic chart form has been implemented 2/15/19 to place insulin scale on the documentation form completed by staff. The RN will complete additional training 2/22/19 to further explain process of medication verification specifically as it pertains to insulin. She will re-integrate that deviations from the approves administrative methods only can be approved by RN. Describe your plans to make sure the above happens. The QP's will check the MARs monthly, line by line, to assume proper administration of all medication, most particularly insulin. Any error found will be highlighted, a med error form completed, and corrective action done with staff who were trained. The QP's will stagger the monthly visits. The RN will continue to check the MAR no less than no less than quarterly. This includes the Home Diabetic Chart form. Client #1, diagnosed with diabetes, was administered the wrong dose of a sliding scale insulin 16 times between 1/4/19 and 2/14/19. Although the most current order for the sliding scale insulin was available in the record, three levels of supervision, beyond the staff member that incorrectly transcribed the dosage information, were unaware of the errors until the	{V 118}		

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{V 118}	Continued From page 5 survey. Receiving the wrong dose of insulin was detrimental to the health, safety and welfare of client #1. This is an Imposed Type B rule violation. An administrative penalty of $200.00 per day will be assessed for each day beyond the 30th day the deficiency remains out of compliance.	{V 118}		