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| V 000 | INITIAL COMMENTS<br><br>An annual and follow-up survey was completed 12/4/18. Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. | V 000 | | |
| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(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.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(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.<br>(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:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug;<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and<br>(E) name or initials of person administering the drug.<br>(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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This Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed ensure Medication Administration Records (MAR) were kept current for 1 of 3 clients (#3). The facility also failed to ensure 1 of 3 clients (#1) received medications as ordered by her physician. The findings are:

1. The following reflects the failure to keep MARs current.

Observation on 11/19/18 of client #3's medications revealed Losartan HCTZ 100-12.5 mg tablets, used to treat hypertension, were present.

Review on 11/19/18 of client #3's record revealed:
- a physician's order dated 7/3/18 with instructions for one Losartan HCTZ 100-12.5 mg tablet to be administered
once daily
- the November 2018 MAR did not have Losartan HCTZ listed on the MAR

During an interview on 11/19/18, the Lead Staff reported Losartan HCTZ was given daily but she failed to make sure Losartan was transcribed onto the November 2018 MAR as it was for previous months.

During an interview on 11/19/18, client #3 reported she received her medications on time daily.

[A medication count was performed and the count

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| V 118 | Continued From page 2<br>reflected an amount that would indicate the medication was administered].<br><br>2. The following reflects the facility's failure to administer medications on the written order of a person authorized to prescribed medications.<br><br>Observation on 11/19/18 at approximately 11:20 AM of client #1's medications revealed Novolog Flexpen insulin was present.<br><br>Review on 11/19/18 of client #1's record revealed:<br>- admission date 5/6/08<br>- an FL2 dated 2/12/18 with diagnoses including Moderate Intellectual and Developmental Disabilities and Diabetes<br>- a nurse practitioner's order dated 8/6/18 for Novolog sliding scale insulin had instructions to administer: 0 units for<br>a blood sugar reading less than 100; 3 units for 101 - 150; 4 units for 151 - 200; 6 units for a reading above 200<br>and 8 units for a reading above 300; on weekdays when client #1 goes to her day program add 1 unit to the scale<br>for each meal unless blood sugar reading is below 100; do not give Novolog on weekends when at group home,<br>add 1 unit only at supper, unless blood sugar is less than 100... Do not give Novolog. Avoid snacking, avoid<br>chips, limit fruit. Call for frequent blood sugars less than 100 or greater than 200.<br>- the same nurse practitioner wrote another order dated 8/30/18 for Novolog sliding scale insulin with instructions<br>to administer the following: blood sugar less than 80 = 0 units; 81-100 =2 units; 101-150 = 4 units; 151-200 = 5<br>units; 201-300 = 7 units; greater than 300 = 8 | V 118 | | |

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| V 118 | Continued From page 3<br>units twice daily at breakfast and supper Monday through Friday;<br>three times a day at each meal on Saturday and Sunday.<br><br>Review on 11/19/18 of the MAR book revealed the sliding scale order from the 8/6/18 order had been transcribed onto client #1's September, October and November 2018 MAR sheets rather than the most current 8/30/18 order.<br><br>Review on 11/19/18 of client #1's blood sugar readings from 9/14/18 to 11/19/18 revealed out of 212 times client #1's blood sugar was checked in the morning before breakfast, before lunch on weekends, before supper and before bed, the wrong dose of sliding scale Novolog insulin was administered incorrectly 170 times:<br>- 166 times the dose given was 1 unit less than the 8/30/18 order called for<br>- twice the dose given was 2 units less<br>- twice the dose given was 4 units less<br><br>During an interview on 11/19/18, the Lead Staff reported she transcribed orders onto the medication administration record (MAR) sheet. The Lead Staff stated she didn't realize until the surveyor pointed out that two different orders were in the MAR book that she had transcribed the wrong order onto the MAR and therefore the sliding scale dosages had been off.<br><br>During an interview on 11/19/18, the Manager reported she had just been assigned to supervise the facility on October 15, 2018. The Manager reported 11/19/18 was the most time she had spent at the facility since being assigned the Manager for the home. The Manager reported she had not been trained in diabetes management yet. | V 118 | | |

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| V 118 | Continued From page 4<br><br>During an interview on 11/20/18, the Qualified Professional (QP) reported he was "not into the medication part of things." The QP reported when he looked at MARs it was to assure staff filled initials into the boxes. The QP reported he did not check physicians' orders to see if information transcribed onto the MAR sheets was correct. The QP reported the agency had a nurse that reviewed that information. The QP reported he was not aware staff were using the wrong sliding scale for client #1.<br><br>During an interview on 11/16/18, the Registered Nurse (RN) reported she was new to the agency and was just getting acquainted with the clients. The RN reported her most recent work experience was working with pediatric urology patients. The RN reported working with adults, some with diabetes, would be different from the last population she worked with.<br><br>During an interview on 11/30/18, the Former Registered Nurse (FRN) reported she had worked with the agency for more than 20 years. The FRN reported that until about two months ago, she visited all the agency's homes and her duties included:<br>- training staff<br>- reviewing MARs including client #1's blood sugar readings<br>- checking medical records<br>- spoke with staff about doctors' orders<br>- spoke with doctors for clarity about orders as needed<br>- observing staff/client interactions<br><br>During continued interview on 11/30/18 the FRN reported she did not recall seeing discrepancies in the amount of sliding scale insulin administered | V 118 | | |

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to client #1 but did sometimes see that staff failed to enter the amount of insulin given. The FRN reported a copy of the signed order for client #1's sliding scale insulin was maintained in the MAR book. The FRN reported client #1's sliding scale order did not change often while she worked there. The FRN reported her last day at the facility was 9/7/18. The FRN reported client #1 was a "brittle diabetic" and her medicine needed to be given the way the doctor ordered it.

During an interview on 11/28/18, the Family Nurse Practitioner's (FNP) reported the effects of staff giving a unit more or less than prescribed would depend on what the client ate. If staff were administering 'way more, like 10 units more" of insulin, that would be "more of an issue". The FNP "preferred the staff follow the scale as written" but was not really concerned about a unit more or less. The FNP reported she would like staff to be "more cognizant of following the most current order". The FNP reported staff were good about bringing in client #1's blood sugar readings information and she tried to review the orders each time client #1 came to the clinic. The FNP stated she "would recommend a nurse review the MARs to be sure orders are transcribed correctly."

During an interview on 11/19/18, client #1 reported she was doing good. Client #1 reported her blood sugar was "up and down especially when I go out to eat with my dad and fiance."

During an interview on 11/21/18, the Executive Director (ED) reported the Lead Staff transcribed orders onto the MAR and the Manager should go behind staff to make sure the MAR is transcribed correctly. The ED reported the QP was at the home about once per month. The ED reported

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| V 118 | Continued From page 6<br><br>the QP check MARs for completion and may observe a medication pass to assure staff are therapeutic but it was not her expectation the QP monitor medical issues because he did not have a medical background. The ED reported the Nurse was responsible for: monitoring the MARs, review of data sheets, checking orders, checking for expired medications and observing medication passes and training staff in medication administration. The ED reported the current Nurse was new and she was not holding her responsible for any issues.<br><br>Review on 12/4/18 of a Plan of Protection completed 12/4/18 and signed by the Executive Director revealed:<br><br>What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm?<br><br>Individuals in the Franklin County Group Home who have diabetes, including and specifically client #1, the client will be taken to Endocrinologist for clarification of sliding scale via inservice. Oversight of the application of the scale will be completed by the Lead Staff, Residential manager, RN [Registered Nurse] QP and ED. The RN will review the physician's orders transcriptions for accuracy. Management reviewing the MAR will sign at the bottom of the MAR indicating review, the Lead staff will primarily transcribe monthly, the Residential Manager and a QP will review and initial monthly behind the Lead Staff and the RN will review and initial quarterly. The most current orders will be present in MAR to minimize confusion.<br><br>Describe your plans to make sure the above happens. | V 118 | | |

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| V 118 | Continued From page 7<br><br>The ED will review the MAR monthly at supervision assure that all levels of chain of command are monitoring and reviewing MAR and transcriptions.<br><br>The ED will schedule a diabetes class for all levels of staff in Franklin Count Group Home, with the RN in December 2018, to assure proper knowledge and implementation of diabetic care.<br><br>Client #1, diagnosed with diabetes, was administered the wrong dose of a sliding scale insulin 170 out of 212 times over a two month period. Although the most current order for the sliding scale insulin was available in the record, four levels of supervision, beyond the staff member that incorrectly transcribed the dosage information, were unaware of the error until the survey. Receiving the wrong dose of insulin was detrimental to the health, safety and welfare of client #1. This is a recited deficiency and a Type B rule violation and must be corrected within 30 days. 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 | | |