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| V 000 | INITIAL COMMENTS<br><br>A follow-up survey was completed 5/3/19. A deficiency was cited.<br><br>This was a second follow-up to an annual survey completed 12/4/18. The facility Executive Director requested this follow-up survey after relaying the facility was in compliance as of 2/22/19.<br><br>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<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 | V 118 | | |

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| V 118 | Continued From page 1<br>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.<br><br>This Rule is not met as evidenced by:<br>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). In addition, based on record review and interviews, 2 of 3 staff administering medication failed to demonstrate competency (Lead Staff, staff #1). The findings are:<br><br>Review on 4/17/19 of Lead Staff's record revealed:<br>- training on the Home Diabetic Chart was completed 2/15/19 and 2/22/19<br>- additional Diabetes training completed 3/27/19<br><br>Review on 4/17/19 of staff #1's record revealed:<br>- training on the Home Diabetic Chart was completed 2/15/19 and 2/22/19<br><br>Review on 4/17/19 of Executive Director/Qualified Professional's record revealed:<br>- training on the Home Diabetic Chart was completed 2/15/19 and 2/22/19<br>- additional Diabetes training completed 3/27/19<br><br>Review on 4/17/19 of Qualified Professional #2's record revealed:<br>- training on the Home Diabetic Chart was | V 118 | | |

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| V 118 | Continued From page 2<br>completed 2/15/19 and 2/22/19<br>- additional Diabetes training completed 3/27/19<br><br>Review on 4/17/19 of client #1's record revealed:<br>- admission date 5/6/08<br>- diagnoses including Moderate Intellectual and Developmental Disabilities and Diabetes<br>- 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; re-check blood sugar in 1 hour, if still greater than 300, call doctor<br>- a "Home Diabetic Chart" had documentation that reflected client blood sugar measurements<br>- on 3/1/19 at 5:00 PM client #1's blood sugar (BS) measured 315 and 8 units of sliding scale insulin were administered; at 6:00 PM the BS measured 226 and 7 additional units of sliding scale insulin were given by Lead Staff<br>- on 3/3/19 at 5:00 PM client #1's BS measured 404 and 8 units of sliding scale insulin were given; at 6:00 PM the BS measured 279 and 7 additional units of sliding scale insulin were given by staff #1<br>- on 3/20/19 at 5:00 PM client #1's BS measured 330 and 8 units of sliding scale insulin were given; at 6:00 PM the BS measured 152 and 5 additional units of sliding scale insulin were given by staff #1<br>- on 4/3/19 at 5:00 PM client #1's BS measured 325 and 8 units of sliding scale insulin were given; at 6:00 PM her BS measured 134 and 4 additional units of sliding scale insulin were given by staff #1<br>- on 4/7/19 at 5:00 PM client #1's BS measured 321 and 8 units of sliding scale insulin were given; at 6:00 PM the BS measured 263 and 7 | V 118 | | |

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| V 118 | Continued From page 3 | V 118 | | |

additional units of sliding scale insulin were given by Lead Staff
- the Home Diabetic Chart documentation was reviewed and initialed several times monthly by Executive Director/ Qualified Professional #1 (ED/QP#1) and Qualified Professional #2 (QP#2)
- the agency Registered Nurse (RN) reviewed and initialed the Home Diabetic Chart documentation on 4/12/19

During an interview on 4/17/19, the ED/QP #1 was asked why staff administered additional sliding scale insulin at 6:00 PM without consulting with the on-call doctor when client #1's blood sugar was coming down. The ED/QP #1 reported the instructions didn't say not to.

During an interview on 4/25/19, the Lead Staff reported on two occasions, she spoke with on-call endocrinology doctors when client #1's blood sugar measured 300 or higher after a re-check and she was told to give 4 additional units of sliding scale insulin both times. Lead staff reported that depending on the time of day when client #1's blood sugar was high, the instructions would differ. If the BS was high early in the day, she would be instructed to give additional insulin after the re-check. If the BS was high after the re-check in the evening, she would be instructed not to give the sliding scale insulin because the client received a different type of insulin at hour of sleep.

During an interview on 5/2/19, the agency RN reported she never spoke with a staff person regarding what client #1's blood sugar measured during a re-check. The RN reported she thought staff inferred that they should give the second dose of sliding scale insulin based on what they had been told previously by endocrinology clinic

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| V 118 | Continued From page 4<br>staff. The RN reported she did training with staff on what to do if client #1's BS measured 300 or higher and sliding scale insulin needed to be administered and to re-check the BS after 1 hour and to call the clinic doctor if the blood sugar was still 300 or higher. The RN reported she did not train staff on what to do if client #1's BS was found to be coming down during the re-check.<br><br>During an interview on 4/17/19, endocrinology clinic RN reported the client's doctor stated the sliding scale insulin should only be given before meals, twice daily except on weekends. If the blood sugar measured 300 or higher, 8 units of the sliding scale insulin should be given and the staff would recheck the blood sugar an hour later. If the blood sugar was coming down, no additional sliding scale insulin should be given.<br><br>Review on 5/3/19 of a Plan of Protection dated 5/3/19 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>"Immediately upon notification of additional errors, the Executive Director inserviced all staff of FCGH [Franklin County Group Home] on 4/18/19 regarding not giving additional insulin in the contingent situation where her blood sugar was 300, units administered per physician's order and the blood sugar is coming down. The agency is seeking additional clarification in writing from the Endocrinologist, and if support is not given to the agency, another Endocrinologist is being sought to support the staff, RN, and be responsive to the resident's needs. | V 118 | | |

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| V 118 | Continued From page 5<br>Describe your plans to make sure the above happens.<br><br>The Executive Director and RN have reached out to the current Endocrinologist for a meeting/ appointment written clarification for all contingencies of administration will be sought. In addition, the resident has signed a release of records for a second opinion and possible transfer to Dr. [name], an Endocrinologist at [local hospital]. This agency is seeking support for all questions regarding the resident, in a timely manner. The Residential Manager will continue to check the Diabetic Charts multiple times weekly, the QP's will check it monthly and the RN will check it no less than quarterly. The RN will be available to provide training and answer questions as needed and remains on call for constant staff availability."<br><br>This deficiency was cited as a Type B Violation during the survey completed December 4, 2018. This deficiency was then cited as an Imposed Type B Violation during the survey completed February 21, 2019, but evidence in this survey has increased the severity of this deficiency.<br><br>This deficiency was cited 6 times on 12/8/15, 11/1/16, 9/21/17, 12/4/18, 2/21/19 and 5/3/19.<br><br>Client #1, diagnosed with diabetes, was administered additional sliding scale insulin by the Lead Staff and staff #1 a total of 4 times between 3/1/19 and 4/17/19 without a physician's order to do so or without consulting with an on call doctor. During each incident, blood sugar measurements revealed the client's blood sugar was coming down after a dose of sliding scale insulin had been administered the hour before. Three levels of supervision, beyond the staff members that | V 118 | | |

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| V 118 | Continued From page 6<br>incorrectly administered additional doses of insulin, were unaware of the errors until this survey. The administration of additional doses of insulin without consulting a doctor was serious neglect of client #1's health. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day. | V 118 | | |