| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL092-579 | A. BUILDING: ______ B. WING ______ | R-C **12/05/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE EMMANUEL HOME III** | **5212 SWEETBRIAR DRIVE RALEIGH, NC 27609** |

| (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 |
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| V 000 | INITIAL COMMENTS<br><br>A complaint and follow up survey was completed on 12/5/22. The complaint was substantiated (Intake NC#00192072). 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.<br><br>This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 3 current clients & 1 former client. | V 000 | | |
| V 108 | 27G .0202 (F-I) Personnel Requirements<br><br>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS<br>(f) Continuing education shall be documented.<br>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:<br>(1) general organizational orientation;<br>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;<br>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and<br>(4) training in infectious diseases and bloodborne pathogens.<br>(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their | V 108 | | |

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| V 108 | Continued From page 1 | V 108 | | |

equivalence for relieving airway obstruction.
(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.

This Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to provide training to meet the mh/dd needs of the client as specified in the treatment plan for 1 of 4 audited clients (#6). The findings are:

Review on 10/11/22 of client #6's record revealed:
- admitted 10/8/22
- diagnoses of Depression, Diabetes, Hypertension, Seizure Disorder, Autism & Down Syndrome
- treatment plan dated 10/8/22

Observation on 10/11/22 at 11:17am: revealed a caucasian gentlemen at the kitchen table

During interview on 10/11/22 staff #3 reported:
- client #6 was at the facility when he arrived this morning
- he did not know anything about client #6
- staff #1 relieved him and said client #6 came this past weekend
- the Chief Operating Officer (COO) had client #6's record at the facility's office
- the COO was in route to the facility

Observation on 10/11/22 at 1:03pm & 1:32pm

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| V 108 | Continued From page 2<br>revealed:<br>- at 1:03pm the (COO) arrived to the facility with documentation in a folder for client #6<br>- at 1:32pm the COO requested staff #3 review client #6's treatment plan<br><br>During interview on 10/12/22 staff #1 reported:<br>- worked 10pm - 7am<br>- met client #6 on 10/10/22<br>- there was no record at the facility for him<br>- the COO called on 10/10/22 & told her he had seizures<br>- she (COO) asked her thoughts about client #6<br>- she told the COO "hell I just met him"<br><br>During interview on 10/11/22 the COO reported:<br>- she was not available on 10/10//22<br>- planned to be here this morning (10/11/22) to review client #6's record with staff #3<br>- she had an emergency this morning and staff #3 had to attend clients' appointments<br><br>During interview on 11/15/22 the Licensee/Registered Nurse reported<br>- all staff received training on client #6's diagnoses shortly after he was admitted | V 108 | | |
| V 113 | 27G .0206 Client Records<br><br>10A NCAC 27G .0206 CLIENT RECORDS<br>(a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to:<br>(1) an identification face sheet which includes:<br>(A) name (last, first, middle, maiden);<br>(B) client record number;<br>(C) date of birth;<br>(D) race, gender and marital status; | V 113 | | |

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| V 113 | Continued From page 3<br>(E) admission date;<br>(F) discharge date;<br>(2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV;<br>(3) documentation of the screening and assessment;<br>(4) treatment/habilitation or service plan;<br>(5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician;<br>(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;<br>(7) documentation of services provided;<br>(8) documentation of progress toward outcomes;<br>(9) if applicable:<br>(A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM);<br>(B) medication orders;<br>(C) orders and copies of lab tests; and<br>(D) documentation of medication and administration errors and adverse drug reactions.<br>(b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and | V 113 | | |

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| V 113 | Continued From page 4 | V 113 | | |

interview the facility failed to maintain an individual client record for 1 of 4 audited clients (#6). The findings are:

Observation on 10/11/22 at 11:17am: revealed a caucasian gentlemen at the kitchen table

Observation on 10/11/22 at 1:03pm revealed the Chief Operating Officer (COO) arrived to the facility with documentation in a folder for client #6

Observation on 10/11/22 at 1:32pm revealed the following:
- the COO gave staff #3 client #6's treatment plan and asked him to review it

Review on 10/11/22 of client #6's record revealed:
- admitted 10/8/22
- diagnoses of Depression, Diabetes, Hypertension, Seizure Disorder, Autism & Down Syndrome
- treatment plan dated 10/8/22

During interview on 10/11/22 staff #3 reported:
- client #6 was at the facility when he arrived this morning
- he did not know anything about client #6
- staff #1 relieved him and said client #6 came the past weekend
- the COO had client #6's record at the facility's office

During interview on 10/11/22 the COO reported:
- she was not available on 10/10//22
- planned to be here this morning (10/11/22) to review client #6's record with staff #3
- she had an emergency this morning and staff #3 had to attend clients' appointments

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| V 116 | Continued From page 5 | V 116 | | |
| V 116 | 27G .0209 (A) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(a) Medication dispensing:<br>(1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe.<br>(2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing.<br>(3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10 NCAC 26E .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing.<br>(4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule. | V 116 | | |

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| V 116 | Continued From page 6<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure staff did not dispense medications for 1 of 1 former client (FC#7). The findings are:<br><br>Review on 10/3/22 of FC#7's record revealed:<br>- admitted 3/8/22 and discharged 9/16/22<br>- diagnoses of: Autism, Schizoaffective Disorder, Anxiety Disorder, unspecified Depressive Disorder<br>- FL2 dated 5/10/22: Clozapine 150mg (milligram) bedtime & 125mg morning (schizophrenia)<br>- 6/17/22 physician order: Clonazepam .5mg twice day (anxiety)<br>- no physician order PRN (as needed) for Clonazepam .5mg<br><br>Review on 10/6/22 of an email forwarded from FC#7's care coordinator revealed:<br>- email dated 9/5/22 sent to care coordinator and other Local Management Entity/Managed Care Organization representatives from FC#7's mom<br>- attached to the email was a picture of 7 zip lock bags with 2 - 6 small pills placed beside the zip lock bags<br>- each ziploc bag was labeled with the name of the medication, milligram and the dosage, however the client's name was not listed on the zip lock bag<br>- medication names listed on bags were: Clozapine 5mg once a day (PRN) (3 pills), Clozapine 100mg (1) at 7am Sunday and (1) at 7am Monday (2 pills), Clonazepam .5mg take one tonight at 7pm, 7am & 7pm Sunday, and one 7am | V 116 | | |

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| V 116 | Continued From page 7 | V 116 | | |

Monday (4 pills), Clozapine 50mg 3 bedtime Saturday & Sunday (6 pills)
- "...upon arrival for pick up on Saturday...medications packed in an envelope with a paper for me (FC#7's mom) to sign...discovered there were inaccuracies...not only were the medications for Sunday night as well as Monday morning were not included in the envelope, the written instructions for Clonazepam .milligrams (mg) were not clear and on the medication sign sheet for Clonazepam 0.5mg, the amount packaged was left blank..."

During interview on 10/11/22 staff #3 reported:
- first find out how many days the client would be on therapeutic leave (TL)
- he then popped out pills based on the number of days the client was on TL
- he placed the pills in a ziploc bag
- wrote the name of the medication, dosage and the instructions on the ziploc bag

During interview on 10/3/22 Former Staff #4 reported:
- when a client went on TL, control medications were placed in a brown envelope
- staff "popped" the pill out of the pill pack
- staff and parent sign the medication relief form
- the Chief Operating Officer (COO) told her "to do it this way"

During interview on 10/3/22 the COO reported:
- control medications were popped out of the pill pack
- the pills were placed in an envelope based on the number of days the client would be on TL
- the envelope was labeled with the client's name, name of pill, time medication to be given and dosage

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| V 116 | Continued From page 8<br>- the guardian would sign a medication release form<br>- if the guardian felt comfortable to administer from the pill pack, then the entire pill pack was sent | V 116 | | |
| V 117 | 27G .0209 (B) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(b) Medication packaging and labeling:<br>(1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible;<br>(2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate;<br>(3) The packaging label of each prescription drug dispensed must include the following:<br>(A) the client's name;<br>(B) the prescriber's name;<br>(C) the current dispensing date;<br>(D) clear directions for self-administration;<br>(E) the name, strength, quantity, and expiration date of the prescribed drug; and<br>(F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. | V 117 | | |

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| V 117 | Continued From page 9<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview the facility failed to retain the manufacturer's label on the medication for 2 of 3 audited clients (#4 & #6). The findings are:<br><br>A. Review on 9/28/22 of client #4's record revealed:<br>- admitted 4/10/20<br>- diagnoses of: Intracranial Hemorrhage, Traumatic Brain Injury, Alcohol Abuse in remission, Prostate Cancer, Insulin Dependent Diabetes Mellitus, Seizure Disorder & Hypertension<br>- FL2 dated 8/18/22: Humalog Kwikpen insulin (based on sliding scale) (diabetes)<br><br>Observation on 9/29/22 at 11:48am of client #4's medication box revealed:<br>- 1 Humalog Kwikpen without the box that contained the pharmacy label<br><br>During interview on 9/29/22 the Chief Operating Officer (COO) reported:<br>- staff must have thrown the box away<br><br>B. Review on 10/11/22 of client #6's record revealed:<br>- admitted 10/8/22<br>- diagnoses of Schizophrenia, Depression, Diabetes, Hypertension, Seizure Disorder, Autism & Down Syndrome<br>- a FL2 dated 10/3/22 with the following recorded: "do not use this FL2 as official medication orders...please verify with attached discharge summary":<br>- Xanax 25mg three times a day (anxiety) | V 117 | | |

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| V 117 | Continued From page 10<br>- Ferrous Sulfate 325mg every other day (iron deficiency)<br>- Levetiracetam 1000mg twice day (seizure)<br>- Vitamin D3 daily (calcium)<br>- Prozac 20mg daily (depression)<br>- Lisinopril 20mg morning (high blood pressure)<br>- Dilantin (300mg) every 12 hours (seizure)<br>- Propranolol 10mg three times day (high blood pressure)<br>- Metformin 500mg daily (diabetes)<br>- Trazadone 50mg (PRN) (depression)<br>- Aripiprazole 20mg daily (schizophrenia)<br><br>Observation on 10/11/22 at 2:03pm of client #6's medication box revealed:<br>- a pill planner<br>- the pill planner was labeled with the following: days of the week, morning, noon, evening & bedtime<br>- a variety of pills with different color and sizes inside each compartment<br>- no label which identified: the client's name & name of the pills, strength or dosage<br><br>During interview on 10/11/22 & 10/12/22 the COO reported:<br>- client #6's sister dropped him off with a week of medications in a pill planner<br>- staff "administered the medications from the pill planner"<br><br>During interview on 11/15/22 the Licensee/Registered Nurse reported:<br>- "the pill planner was not ideal & would not recommend it but was an emergency situation" | V 117 | | |
| V 118 | 27G .0209 (C) Medication Requirements | V 118 | | |

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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.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to administer medications on the written

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order of a physician for 2 of 3 audited clients (#4 & #6) & failed to keep 1 of 3 audited client's (#6) MAR current. The findings are:

I. The following is an example of how the facility failed to have a system in place to record client #4's Blood Sugar (BS) to ensure he was being administered the correct dose of insulin:

Review on 9/28/22 of client #4's record revealed:
- admitted 4/10/20
- diagnoses of: Intracranial Hemorrhage, Traumatic Brain Injury, Alcohol Abuse in remission, Prostate Cancer, Insulin Dependent Diabetes Mellitus, Seizure Disorder & Hypertension

Review on 9/28/22 of a physician order dated 5/6/22 revealed:
- check BS before meals and at bedtime
- Humalog Kwikpen Insulin test 3 times a day before meals (sliding scale/Diabetes)
- do not give Humalog Kwikpen Insulin at bedtime. It should be given only with meals
- sliding scale insulin dosage:
  70 - 150 - 0 units
  151 - 200 - 2 units
  201-250 - 4 units
  251- 300- 6 units
  301 - 350 - 8 units
  over 350 - 10 units

Review on 9/28/22, 10/3/22 & 10/17/22 of client #4's BS from July 2022 - October 2022 revealed:
- BS were recorded in different places such as: index cards, the facility's BS logs and the MARs
- missing dates & times of BS results
- missing insulin units administered
- insulin administered at bedtime

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A. July 2022 BS Logs
- 2 different BS logs for July 2022
- one BS log will be identified as July 2022 BS log #1
- the second BS log identified as July 2022 BS log #2

July 2022 BS log #1 from 7/8 - 7/12 revealed:
- the incorrect amount of insulin was administered on the following date:
- 7/8 - 5pm - 218: 2 units administered
- 7/12 was the last day BS results & insulin results were recorded

July 2022 BS log #2 revealed:
- written at the top of the BS log "blood sugars recorded on MAR sheet"
- no BS recorded on the following dates: 7/8 - 7/10, 7/18-7/20, 7/22, 7/26-7/28
- BS was recorded only once a day for the following dates: 7/11-7/14, 7/15, 7/21, 7/23-7/25
- BS was recorded only twice a day for the following dates: 7/16 - 7/17
- insulin units were not recorded for the following BS results:
- 7/11 - 8:55am: 160
- 7/12 - 11:55am: 189
- 713 - 4:50pm: 222
- 7/16 - 6:31pm: 272
- 7/25 - 7:31pm: 189
- written out of date order at the bottom with no insulin units recorded:
- 7/16 - 7:16am: 219
- 7/17 - 8:09 no am/pm recorded: 169

July 2022 MAR revealed:
12pm:
- no BS recorded 7/26 & 7/29

5pm:

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- the incorrect amount of insulin was administered on the following dates:
- 7/8 - 218: 2 units administered
- 7/23 - 201: 1 unit administered
- no insulin units recorded on the following dates:
- 7/13- 227: 0 units
- 7/20 - 277: 0 units
- 7/30 - 155: 0 units
- no BS recorded on the following dates:
- 7/28 - 7/29

B. There was no August 2022 BS log

August 2022 MAR revealed the following:
- "no insulin given at bedtime"

7am:
- no insulin units recorded on the following date:
- 8/21 - 185: 0 units
- the incorrect amount of insulin was administered on the following dates:
- 8/27- 226: 2 units
- 8/28 - 172: 8 units
- no BS recorded on 8/6 & 8/30

12pm:
- no BS recorded on the following dates: 8/1, 8/21 & 8/26 & 8/31
- the incorrect amount of insulin was administered on the following dates:
- 8/7 - 203: 2 units
- 8/8 - 190: 6 units
- 8/9 - 243: 6 units
- 8/13 - 208: 6 units
- 8/14 - 168: no units
- 8/15 - 152: 2 units
- 8/20 - 228: 0 units
- 8/27 - 153: 0 units

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5pm:
- no BS recorded on the following date: 8/15
- the incorrect amount of insulin was administered on the following dates:
- 8/17 - 175: 0 units
- 8/21 - 216: 3 units

8pm (bedtime):
- no insulin to be given at bedtime:
- 8/11/22 - 174: 2 units

C. September 2022 BS log revealed the following:
- labeled at the top: am glucose/insulin, pm glucose/insulin & bedtime
- no BS recorded on the following dates: 9/1-9/4, 9/8, 9/10-9/26, 9/28, 9/30-9/31
- the incorrect amount of insulin was administered on the following date:
- 9/9 (pm) 209: 2 units

September 2022 MAR revealed the following:
- no BS recorded on: 9/1-9/15, 9/22, 9/25 & 9/29-9/30
- the incorrect amount of insulin was administered on the following dates:
- 9/16 - 2pm: 180: no units
- 9/17 - 2pm: 157: no units
- 9/19 - 8am-196: no units
- 9/21 - 8am-180: no units
- 9/26 - 8am-218: no units
- 9/27 - 8am-161: no units
- 9/28 - 8am-181: no units
- written out of date order at the bottom with incorrect units recorded:
- 9/15- 12pm -196: no units
- 9/15 - 5pm - 211: no units
- written at the bottom was 182 with no date, time or insulin unit administered

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September 2022 BS written on index cards revealed the following:
- no am/pm written for the following BS:
- 9/5-7: 97
- 9/5-12: 97
- 9/6- 12: "not here" (not in facility)
- 9/7-7: 102
- no insulin units recorded for the following date:
- 9/7 - 12pm: 276

D. October 2022 BS log revealed the following:
- 10/1 - only am BS recorded
- 10/5 - BS recorded only at bedtime
- no BS recorded on the following date: 10/2
- 10/6-10/8 - no BS recorded in am & noon
- 10/9-10/10 - no BS recorded with "refused" written

October 2022 MAR BS (7am, noon, 5pm & bedtime):
- no BS recorded for the following dates & times revealed the following:

7am:
- 10/5-10/7, 10/12-10/14, 10/18 - 10/21, 10/25 - 10/28, 10/30-10/31

12pm:
- 10/5 - 10/8, 10/10-10/14, 10/17-10/21, 10/25-10/28, 10/30-10/31

5pm:
- 10/10-10/13, 10/17-10-21, 10/24-10/31

8pm:
- 10/1, 10/5, 10/9-10/13, 10/17-10/21, 10/23-10/28, 10/30-31

BS with no insulin units recorded for the following dates:

7am:
- 10/11 - 159
- 10/24 - 284

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12pm:
- 10/9 - 219
- 10/16 - 208
- 10/29 - 203

5pm:
- 10/3 - 186
- 10/4 - 158
- 10/4 - 158
- 10/8-153

E. Review on 9/28/22 of a signed FL2 for client #4 dated 8/18/22 revealed: Lisinopril 40mg (milligram) daily (blood pressure (BP))

Review on 9/28/22 of a signed FL2 for client #4 dated 1/21/22 revealed: check BP three times day

Review on 10/12/22 of a physician order dated 10/12/22 sent to the Division of Health Services Regulation (DHSR) for client #4 revealed:
- check BP once a day

Review on 11/15/22 of client #4's MARs revealed: no BP recorded on the MARs from July 2022 - October 2022

July 2022 BP log:
- BP recorded only once a day
- no BP recorded on the following dates: 7/9, 7/11 - 7/15, 7/19-7/20, 7/22, 7/25-7/29

No BP log for August 2022

September 2022 BP log:
- BP were recorded on the BS log
- BP recorded once a day in the morning with the exception of 9/8-9/10, 9/20 & 9/26
- BP were recorded as a single number rather than systolic & diastolic BP checks on the

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following dates:
- 9/8 - "102 BP"
- 9/9 - "126 BP"
- 9/10 - "181 BP"

October 2022 BP log:
- BP were recorded once a day from 10/1 - 10/11
- no BP recorded on 10/2 & 10/8

During interview on 9/28/22 staff #2 reported:
- started end of August 2022
- worked 3pm - 11pm
- checked client #4's BS at 5pm & bedtime
- sometimes ran out of the BS logs
- would document the BS on an index card or sticky notes
- ran out of the BS logs a few weeks ago
- he informed the Licensee/Registered Nurse (L/RN)
- management told him last week client #4's BP needed to be check
- wrote the BP on a piece of paper

During interview on 10/3/22 staff #3 reported:
- began work end of August 2022
- worked 7am - 3pm
- was told to write BS/BP on the facility's log
- ran out of the BS/BP logs
- wrote the BS/BP on index cards and sticky notes for a week in September 2022
- did not notify management BS/BP logs were needed

During interview on 10/7/22 former staff #4 reported:
- left facility in September 2022
- she needed eye surgery & made medication errors
- the Chief Operating Officer (COO) & L/RN

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would inform her of the medication errors
- she recorded BS/BP on the MAR & BS/BP logs
- sometimes ran out of the BS/BP logs & notified the COO
- would document the BS/BP on a piece of paper if not on the MAR or BS/BP logs

During interview on 9/28/22 the COO reported:
- staff needed to notify her when the BS/BP logs ran out
- preferred the BS/BP to be recorded on the BS/BP logs
- aware staff recorded BS/BP on index cards
- she normally transcribed the BS/BP from the index cards to the BS/BP logs
- have not had time to transcribe the BS/BP from the index cards to the BS/BP logs

During interview on 11/15/22 the L/RN reported:
- client #4 was combative at times and would refuse BS/BP checks
- if BS/BP were not recorded on the MAR, staff would document it on index cards and sheets of paper

II. The following is an example of how the facility's staff failed to follow physician's orders & keep the MAR current:

Review on 10/11/22 of client #6's record revealed:
- admitted 10/8/22
- diagnoses of Schizophrenia, Depression, Diabetes, Hypertension, Seizure Disorder, Autism & Down Syndrome
- a FL2 dated 10/3/22 with the following recorded: "do not use this FL2 as official medication orders...please verify with attached discharge summary":
- Xanax 25mg three times a day (anxiety)

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| V 118 | Continued From page 20<br>- Ferrous Sulfate 325mg every other day (iron deficiency)<br>- Levetiracetam 1000mg twice day (seizure)<br>- Vitamin D3 daily (calcium)<br>- Prozac 20mg daily (depression)<br>- Lisinopril 20mg morning (high blood pressure)<br>- Dilantin (300mg) every 12 hours (seizure)<br>- Propranolol 10mg three times day (high blood pressure)<br>- Metformin 500mg daily (diabetes)<br>- Trazadone 50mg (PRN) (depression)<br>- Aripiprazole 20mg daily (schizophrenia)<br><br>Observation on 10/11/22 at 1:50pm of client #6's medication box revealed:<br>- medication bottles with the above medications listed on the label with the exception of: Metformin, Trazadone & Aripiprazole<br>- a pill planner labeled with the following: days of the week, morning, noon, evening & bedtime<br>- a variety of pills with different color and sizes inside each compartment<br>- no label which identified: the client's name & name of the pills, strength or dosage<br><br>Review on 10/11/22 of the facility's MAR book revealed:<br>- no October MAR for client #6<br><br>Review on 10/12/22 of an email sent to the Division of Health Service Regulation (DHSR) from the COO revealed:<br>- an October 2022 MAR for client #6<br>- medications from 10/9/22 - 10/12/22 initialed by staff #1, #2, #3 & #4<br>- staff #1's initials were only listed for Prozac on 10/10/22 - 10/11/22<br>- Metformin & Trazadone were not listed<br>- an incident report dated 10/11/12 for client #6 | V 118 | | |

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completed 10/12/22 by COO & signed by L/RN "...type of error: missed dose...staff (#3) states medications was not given. Staff states he could not find MAR" "MAR was worked on throughout the weekend. Residents family packed mediation for one week. A PCP (primary care physician) appointment, MH (mental health) appointment has been requested"

Review on 10/12/22 of a text message sent by staff #1 to the COO revealed:
- dated 10/12/22
- "...I can't work tonight, I'm actually upset because [staff #3] or you (COO) lied on me to [DHSR surveyor] but I told her the truth. I didn't give new guy (client #6), meds (medication) yesterday or today and [staff #3] was aware and told me he would give it. I never signed a MAR but my initials are on it. Meaning yall forged my signature. I just don't appreciate that. The only reason why he didn't get meds (medication) is because he was slow moving...and [staff #3] came in and I told him and he said he would give it."

During interview on 10/11/22 & 10/12/22 the COO reported:
- client #6's sister dropped him off with a week of medications in a pill planner
- staff "administered the medications from the pill planner"

During interview on 11/15/22 the L/RN reported:
- "the pill planner was not ideal & would not recommend it but was an emergency situation"

During interview on 10/11/22 staff #3 reported:
- client #6 was at the facility when he arrived to work this morning
- he did not administer any of client #6's

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morning medications
- staff #1 (third shift) administered his morning medications
- he did not know where client #6's MAR was

During interview on 10/12/22 staff #1 reported
- worked from 10pm - 7am
- she met client #6 for the first time Monday night (10/10/22)
- did not administer client #6 any medications
- client #6 "moved slow in the mornings" and she had to pick her son up by 8am
- staff #3 said he would administer client #6's morning medications
- client #6 did not have a MAR at the facility
- she relieved staff #2 on 10/10/22
- staff #2 informed her he administered client #6's medications with no MAR

During interview on 11/15/22 staff #2 reported:
- worked second shift (3pm - 11pm)
- he met client #6 on 10/10/22
- there was a blank MAR for client #6
- he transcribed the medications on the MAR
- the COO reviewed the MAR after he transcribed it

During interview on 10/17/22 the pharmacy reported:
- no physician's order for client #6's Metformin
- too soon to fill the Aripiprazole
- Trazadone was sent to the facility today

During interview on 10/11/22 & 10/12/22 & 11/15/22 the COO reported:
- the L/RN transcribed client #6's MAR when he was admitted on 10/8/22
- client #6 had an appointment next week with his physician
- medication orders would be obtained at the

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| V 118 | Continued From page 23<br>time of the appointment<br>- was not aware client #6 was on Metformin & would follow up with the physician<br>- on 10/12/22, she (COO) signed staff #1's initials on client #6's MAR to prevent "holes" (blank spaces) on the MAR<br>- client #6's morning medications had to be administered by staff on the morning of 10/11/22, because the medications were missed from the pill planner<br>- she and the L/RN reviewed MARs for medication errors<br>- all new staff had been hired and medication trained since the last survey (7/7/22)<br><br>During interview on 11/15/22 the L/RN reported:<br>- could not recall if client #6's MAR was transcribed on the day he was admitted<br>- client #6 was admitted on an emergency basis<br>- he did not have anywhere to go<br>- it took time to get client #6 linked to medical providers<br>- visited the facility daily for different reasons: cleanliness of the facility, ensure medications in the facility, grocery & review of MARs<br>- noticed during her review: medication errors<br>- it was "impossible" for her and the COO to review MARs daily<br>- recently hired a previous staff to oversee the medication system<br>- he was in the process of being trained by her (L/RN)<br>- she was unsure of his start date at the facility<br>- it was a "constant job" to look for responsible staff<br>- staff were trained on a continuous basis<br>- staff watched medication videos, had in person medication training and staff continued to make medication errors | V 118 | | |

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|---|---|---|---|---|
| V 118 | Continued From page 24<br><br>Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.<br><br>Review on 12/5/22 of the Plan of Protection dated 12/5/22 written by the COO revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? My immediate plans as of today is to coordinate the Health Coordinator to Emmanuel Home #3 to assist QP (Qualified Professional) with medication needs and State compliance. A review of med (medication) training will also be coordinated and retrained to staff in the next 30 days after today.<br><br>Describe your plans to make sure the above happens. 1) Review of training and methods of training 2) weekly review of staff supervision provided by MAR review and QP."<br><br>This deficiency has been cited 3 times since the original cite on 2/16/22.<br><br>Clients whose diagnoses included Traumatic Brain Injury, Diabetes, Prostate Cancer, Schizophrenia, Depression, Hypertension, Seizure Disorder, Autism & Down Syndrome resided at the facility. Client #4's BS/BP were recorded in different locations such as: index cards, on BS/BP logs or the MARS. Insulin was either administered incorrectly or not recorded as administered. Insulin was administered at bedtime on one occasion, even though there was a physician's order requesting no insulin at bedtime. Client #4's BP was to be checked three times a day and it was checked once a day or not at all. There were no documentation for BP | V 118 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL092-579 | A. BUILDING: ______ B. WING ______ | R-C **12/05/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE EMMANUEL HOME III** | **5212 SWEETBRIAR DRIVE RALEIGH, NC 27609** |

| (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 |
|---|---|---|---|---|
| V 118 | Continued From page 25 | V 118 | | |
| | checks at least 23 times and at least 43 times for BS checks. Client #6 was admitted on 10/8/22 and as of 10/11/22, there was no MAR onsite. Upon client #6's admission, staff administered medication from a pill planner. Client #6's Metformin for treatment of his Diabetes was not onsite. The COO filled in a staff's initial on the MAR to prevent blanks from being on the MAR. This deficiency constitutes a Failure to Correct the Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day is imposed for failure to correct within 23 days. | | | |