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| V 000 | INITIAL COMMENTS<br><br>A complaint survey was completed on 1/17/23. The complaint was substantiated (intake #NC 00195059). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.<br><br>This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 1 current client. | V 000 | | |
| V 109 | 27G .0203 Privileging/Training Professionals<br><br>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS<br>(a) There shall be no privileging requirements for qualified professionals or associate professionals.<br>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.<br>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.<br>(d) Competence shall be demonstrated by exhibiting core skills including:<br>(1) technical knowledge;<br>(2) cultural awareness;<br>(3) analytical skills;<br>(4) decision-making;<br>(5) interpersonal skills;<br>(6) communication skills; and<br>(7) clinical skills.<br>(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for | V 109 | | |

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| V 109 | Continued From page 1<br>MH/DD/SAS.<br>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.<br>(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interview, 1 of 1 Qualified Professional/Licensee (QP/L) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are:<br><br>Review on 1/5/23 of the QP/L's personnel file revealed:<br>-Employed since 10/1/13;<br>-Met requirements for a qualified professional.<br><br>Review on 1/5/23 of client #1's record revealed:<br>-Admission date of 1/19/22;<br>-Diagnoses included Diabetes Mellitus, Schizophrenia, Anxiety, Depression and Neurocognitive Disorder;<br>-Orders dated 8/1/22 included check blood sugar levels before every meal and at bedtime and Novolog inject 3 times daily with meals for blood glucose over 150: 151 - 200 2 units, 201-250 4 units, 251 - 300 6 units, 301 - 350 8 units, 351 - 400 10 units, blood glucose over 400 call doctor;<br>-Licensed Health Professional Support forms | V 109 | | |

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| V 109 | Continued From page 2 | V 109 | | |

completed by a Registered Nurse from the pharmacy used by the facility, "DATE OF EVALUATION: 5/12/22...She (client #1) has multiple blood sugar readings that have not been documented...Insulin injections are not documented consistently...I sat down with the med tech (medication technician) (staff #2) and went over correct documentation, she verbalized understanding...Please make sure all staff is educated further on complete medication orders, FSBS (finger stick blood sugars) and insulin administration for safety of residents and documentation on medications along with blood sugar readings; DATE OF EVALUATION: 8/18/22...She (client #1) continues to have multiple blood sugar readings that have not been documented...I spoke with [the Supervisor In Charge] about insulin and correct documentation, she verbalized understanding...Please make sure all staff is educated further on complete medication orders, FSBS and insulin administration for safety of residents and documentation on medications along with blood sugar readings."

Interview on 1/5/23 with a registered nurse from the pharmacy used by the facility revealed:
-Visited the facility every quarter;
-Expressed her concerns to the Licensee on 8/18/22 that client #1 was not being administered Novolog by staff #2 as ordered;
-Licensee informed her that staff #2 was going to be terminated immediately;
-Informed by the Assistant Director on 11/16/22 that staff #2 was still employed at the facility.

Interview on 1/5/23 with the Assistant Director revealed she was aware that the registered nurse from the pharmacy the facility utilized had called the Licensee to complain but she wasn't sure

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| V 109 | Continued From page 3<br>when or why.<br><br>Attempted interviews with the QP/L on 1/5/23, 1/6/23 and 1/9/23 were not successful as he didn't respond to voicemails.<br><br>This deficiency is cross referenced in to 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days. | V 109 | | |
| 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. | V 118 | | |

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| V 118 | Continued From page 4<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 record reviews and interviews, the facility did not ensure medication was administered on the written order of a physician affecting 1 of 1 audited client (#1). The findings are:<br><br>Cross Reference: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record reviews and interview, 1 of 1 Qualified Professional/Licensee (QP/L) failed to demonstrate knowledge, skills and abilities required by the population served.<br><br>Review on 1/9/23 of staff #1's personnel record revealed:<br>-Hire date of 5/4/20;<br>-Documentation of Medication Administration training completed 7/16/20 and 3/27/22 and Diabetes Mellitus training completed 3/31/22.<br><br>Review on 1/9/23 of staff #2's personnel record revealed:<br>-No documentation of hire date;<br>-Documentation of Medication Administration training completed 1/10/15 and Diabetes Mellitus training completed 2/10/17 and 10/23/17. | V 118 | | |

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Review on 1/5/23 of the Supervisor in Charge's (SIC) personnel record revealed:
-Hire date of 10/4/13;
-Documentation of Medication Administration training completed 1/10/15 and Diabetes Mellitus training completed 2/10/17 and 10/23/17.

Review on 1/5/23 of client #1's record revealed:
-Admission date of 1/19/22;
-Diagnoses included Diabetes Mellitus, Schizophrenia, Anxiety, Depression and Neurocognitive Disorder;
-Orders dated 8/1/22 included check blood sugar levels before every meal and at bedtime and Novolog, inject 3 times daily with meals for blood glucose over 150: 151 - 200 2 units, 201 - 250 4 units; 251 - 300 6 units; 301 - 350 8 units, 351 - 400 10 units, blood glucose over 400 call doctor.

Interview on 1/5/23 with client #1 revealed facility staff were supposed to check her blood sugar levels 4 times a day but they didn't always do it.

Finding 1: The facility failed to notify client #1's doctor when they were unable to check blood sugar levels and administer Novolog (if applicable) and of a blood sugar result over 400.

Review on 1/5/23 of client #1's Blood Sugar Log for the month of December 2022 revealed:
-Result of 556 documented on 12/9/22 at 12pm;
-10 units of Novolog was documented as administered because of the 556 result;
-Result of 177 documented on 12/9/22 at 2pm;
-2 units of Novolog was documented as administered because of the 177 result;
-E-2 (error) was documented in place of 2 results on 12/19/22;
-No documentation that the doctor had been notified of the results on 12/9/22 or the error

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messages on 12/19/22.

Review on 1/5/23 of client #1's Blood Sugar Log for the month of January 2023 revealed:
-Out of facility 1/1/23 - 1/3/23;
-No results documented for 1/4/23 or before breakfast for 1/5/23;
-No documentation that the doctor had been notified that staff were unable to check blood glucose on 1/4/23 or before breakfast on 1/5/23.

Interview on 1/5/23 with staff #1 revealed:
-Unable to check client #1's blood sugar levels yesterday (1/4/23) and before breakfast today because the client returned from a home visit on 1/3/23 without her glucometer;
-Client #1's doctor was not notified that she was unable to check blood sugar and administer Novolog (if applicable) on 1/4/23 and today or of error message on 12/19/22;
-Not been informed of what to do when an error message displayed on the glucometer, so she documented the error message.

Additional interview on 1/5/23 with staff #1 revealed:
-Talked with client #1's family and they thought they had packed the glucometer in the client's bag;
-Able to locate client #1's glucometer in her bag.

Interview on 1/9/23 with staff #2 revealed:
-Wasn't aware she was supposed to notify management of blood sugar readings over 400 and not administer Novolog;
-Didn't remember administering 10 units of Novolog to client #1 on 12/8/22 when blood sugar result was 556 and then administering 2 additional units of Novolog 2 hours later when blood sugar result was 177;

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-Not been informed of what to do when an error message displayed on the glucometer, so she documented the error message;
-Client #1's doctor was not notified of an error message on 12/19/22.

Interviews on 1/5/23 and 1/9/23 with the SIC revealed she was aware that staff #1 had been unable to check blood sugar for client #1 since she returned to the facility on 1/3/23 and the doctor had not been notified.

Interview on 1/9/23 with the Assistant Director revealed staff #2 should have contacted either her or the SIC when client #1's blood sugar result was 556 and they would have instructed her to send the client to the hospital.

Finding #2: The facility failed to accurately check and record client #1's blood glucose levels as ordered.

Review on 1/5/23 of client #1's Blood Sugar Log for the month of November 2022 revealed:
-No documentation of results for 11/1/22 - 11/20/22 or 11/26/22 - 11/30/22;
-20 results documented from 11/21/22 - 11/25/22;

Review on 1/5/23 of client #1's glucometer history for the month of November 2022 revealed only 2 results (both on 11/21/22).

Interviews on 1/5/23 and 1/6/23 with the Assistant Director revealed:
-The wrong Blood Sugar Log for the month of November 2022 had been provided and she had located the correct one;
-Had ordered client #1 a new glucometer in November 2022 because the one she had "was acting a fool;"

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| V 118 | Continued From page 8<br>-Located a glucometer that staff had possibly been using that belonged to a former client;<br>-The additional glucometer that had been located was available for review;<br>-Staff were checking client #1's blood sugar levels correctly.<br><br>Additional interview on 1/9/23 with the Assistant Director revealed she had disposed of both glucometers since the interview on 1/6/23 and ordered a new one for client #1 because she was unable to get them to operate correctly.<br><br>Review on 1/9/23 of client #1's additional Blood Sugar Log for the month of November 2022 revealed:<br>-All results were the same handwriting;<br>-4 results documented daily for 11/1/22 - 11/30/22;<br>-Documentation on 11/16/22 of, "Ordered new meter;"<br>-Documentation on 11/17/22 of, "Start new meter."<br><br>Review on 1/5/23 of client #1's MAR for the month of December 2022 revealed she was out of the facility from 12/25/22 - 12/31/22.<br><br>Review on 1/5/23 of client #1's Blood Sugar Log for the month of December 2022 revealed no results documented for 12/1/22 - 12/4/22, 12/22/22 and 12/24/22.<br><br>Review on 1/5/23 of client #1's glucometer history for the month of December 2022 revealed:<br>- No results for 12/1/22 - 12/4/22, 12/22/22 or 12/24/22;<br>-Three or less results for 7 of the remaining 19 days;<br>-Ten results documented on the Blood Sugar Log | V 118 | | |

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didn't correlate with the glucometer history.

Interview on 1/5/23 with staff #1 revealed:
-Aware of only 1 glucometer in the facility;
-Wasn't aware that in November 2022, she documented that she checked client #1's blood glucose levels 43 times but 41 of those results didn't correlate with the glucometer history;
-Wasn't aware that in December 2022, she documented that she checked client #1's blood glucose levels 28 times but 17 results were not documented on the Blood Sugar Log, and 8 of the results didn't correlate with the glucometer history.

Interview on 1/9/23 with staff #2 revealed:
-Didn't know why client #1's glucometer had no record of the result she documented on the Blood Sugar Log on 12/19/22 and 12/21/22;
-"I know I wrote down what's on the thing (glucometer)...There's way too many people in there on it (glucometer)."

Finding #3 The facility failed to accurately administer Novolog to client #1 as ordered.

Review on 1/5/23 of client #1's Blood Sugar Log for the month of December 2022 revealed:
-Staff #1 documented she had administered Novolog before bed twice;
-Staff #2 documented she had administered Novolog before bed 9 times;

Interview on 1/5/23 with staff #1 revealed:
-Thought client #1 had an order to be administered Novolog before bed (if applicable);
-Not aware she administered Novolog in December 2022 to client #1 twice before bed without an order.

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Interview on 1/9/23 with staff #2 revealed:
-Thought client #1 had an order to be administered Novolog before bed (if applicable);
-Wasn't aware that she administered Novolog to client #1 in December 2022 9 times before bed without an order;
-Unable to remember why she documented a blood sugar result of 186 for client #1 on 12/13/22 but didn't document administering 2 units of Novolog as ordered;
-Administered Novolog as ordered but failed to document.

Interview on 1/5/23 with a registered nurse from the pharmacy used by the facility revealed not administering Novolog as ordered can lead to dizziness, trouble speaking, fatigue, confusion, seizures and loss of consciousness.

Review on 1/9/23 of a Plan of Protection dated 1/9/23 completed by the Assistant Director revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? Assistant Director will train on duty staff immediately in the use of glucometer and sliding scale insulin. Will train all staff within the next 14 days on administering insulin, the use of glucometer and the sliding scale insulin.
-Describe your plans to make sure the above happens. Assistant Director will monitor staff check logs to make sure insulin is being administered according to sliding scale. Will educate all staff to ensure insulin is being administered according to order. Will contact the doctor if the blood sugar is over 400."

Client #1 was admitted to the facility on 1/19/22 with diagnoses of Diabetes Mellitus, Neurocognitive Disorder, Urinary Incontinence,

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| V 118 | Continued From page 11<br><br>Uterine Fibroid, Depression, Anxiety, and Schizophrenia. The Q/L didn't ensure staff were competent in checking blood sugar and administering Novolog (if applicable) even after being informed by a registered nurse that she had concerns. During the month of November 2022, a new glucometer was ordered, and once staff started using it, only 2 documented results out of 56 correlated with the glucometer history. During the month of December 2022, client #1's blood glucose wasn't checked and sliding scale insulin wasn't administered as ordered 48 out of 96 times. This included the client being administered units of Novolog before bed with no order 13 of 24 days. Facility staff failed to notify the client's medical provider for a result of 556 and instead administered 10 units of Novolog, rechecked the blood glucose 2 hours later and administered an additional 2 units of Novolog. The client's medical provider also wasn't notified that facility staff were unable to check the client's blood glucose or administer Novolog on 1/4/23 and 1/5/23 because the glucometer couldn't be located. Staff were not knowledgeable about what to do when they received error messages on the glucometer when attempting to check blood glucose. Two error messages were documented in December 2022 and the doctor wasn't notified. The failure of the Licensee to demonstrate competence and the facility staff to follow medication orders, resulted in neglect of the client's diabetic needs and constitutes a Type A1 rule violation for serious neglect which must be corrected in 23 days. An administrative penalty of $2,000.00 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 | | |