STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL007-027	A. BUILDING: ______ B. WING ______	R 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAUFORT COUNTY GROUP HOME #2	**903 EAST SEVENTH STREET** **WASHINGTON, NC 27889**

(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 000	INITIAL COMMENTS An annual and follow up survey was completed on August 25, 2022. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 5 and currently has a census of 5. The survey sample consisted of audits of 3 current clients.	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.	V 118	DHSR - Mental Health JAN 18 2023 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jane S. Purris, BA/QP | TITLE: Program Service Manager | (X6) DATE: 1/12/23

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V 118	Continued From page 1 (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		
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications on the written order of a physician and ensure the MARs were kept current affecting one of three audited clients (#3). The findings are: Review on 08/23/22 of client #3's record revealed: - 51 year old male. - Admission date of 03/01/07. - Diagnoses of Autism Spectrum Disorder with Accompanying Intellectual and Language Impairment, Severe Intellectual Developmental Disability (IDD) and Insulin Dependent Diabetes Mellitus. Review on 08/23/22 of client #3's medication orders signed by the Primary Care Provider revealed: 05/19/22 - "Decrease Basalgar (long acting insulin) from 16u (units) to 14u AM/PM, decrease Novolog (mealtime insulin) from morning inject 4u before breakfast and 5u before lunch/dinner...sliding scale give 1 extra unit for every 50units [greater than] 130 at meals."	V118	It was Noticed that client #3 Physician Had written an order to revise the # of units #3 receives and that staff correctly update the MAR by Hand to match the correct orders. This writer took #3 to his physician and the order from the physician was written on 5/19/22. This Has been corrected and staff Have been following The correct chart as it was updated	10/5/22 → 1/12/23

Division of Health Service Regulation

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V 118	Continued From page 2 06/15/22 - Insta-Glucose 40% Gel (low blood sugar) - Give one tube by mouth if blood sugar value is less than 60. - Notify physician if blood sugar is over 400. Review on 08/23/22 of a facility document attached to client #3's August 2022 MARs revealed the following: - "For Novolog Flex Pen only: Updated 5/19/22 - Breakfast (8am): 4 units - Before lunch (12pm): 5units - Before supper (5pm): 5units - Give extra units when needed: *Add 1 extra unit for every 50 points above 130. (see chart below.)" - The document contained the specific number of units required for breakfast, lunch and supper for the appropriate corresponding blood sugar values. Review on 08/23/22 of client #3's June 2022 through August 2022 MARs revealed: June 2022 - 06/02/22 (412) and 06/21/22 (454) - blood sugar value greater than 400 and no documentation the physician was notified. - 06/19/22 no documentation 1 extra unit was administered at supper for a blood sugar value of 196. - No staff initials that indicate Insta-Glucose was administered for a blood sugar value of less than 60 on 06/09/22 (45), 06/10/22 (45), 06/16/22 (55), 06/23/22 (48) and 06/28/22 (56). July 2022 - 07/02/22 staff #2's signature to indicate 6 units of insulin were administered instead of 7 units at lunch for a blood sugar value of 235. - 07/15/22 staff #2's signature to indicate 8 units of insulin were administered instead of 7 units at	V 118 V118 V118	Staff will give one tube P.O. IF blood sugar IS less than 60. STAFF will Initial on the Front of the MAR the # of units and give explanation on the Back of MAR to show glucose was given. Staff will also contact QP. Immediatly and given #3 The Appropriate amount of sugar units for his Blood sugar being at 400 or above. QP will contact Physician's office for recommendations. Staff will continue to call and document time + Date + contact for the call, on back of MAR. — 1/12/23 Wrong number of Insulin units were given. It IS recommended that Staff pay close attention to the scale that IS provided for correct units before breakfast	1/12/23

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V 118	Continued From page 3 breakfast for a blood sugar value of 311. - 07/31/22 staff #2's signature to indicate 9 units of insulin were administered instead of 7 units at breakfast for a blood sugar value of 288. - No documentation extra insulin was administered as ordered on the following dates and blood sugar values: 07/04/22 (225), 07/12/22 (220) at breakfast, 07/12/22 (345) at lunch, 08/19/22 (200) at breakfast, 08/19/22 (242) at lunch, 07/24/22 (138), 07/31/22 at lunch (193) and supper (188). August 2022 - 08/02/22 staff #2's signature to indicate 8 units of insulin were administered instead of 6 units at breakfast for a blood sugar value of 235. - 08/13/22 staff #2's signature to indicate 8 units of insulin were administered instead of 7 units at breakfast for a blood sugar value of 317. - 08/18/22 the Qualified Professional's signature to indicate 7 units of insulin were administered instead of 8 units at lunch for a blood sugar value of 285. - No documentation extra insulin was administered as ordered on the following dates and blood sugar values: 08/01/22 (283), 08/04/22 (196), 08/05/22 (279), 08/06/22 (205), 08/11/22 (245), 08/12/22 (201) at lunch, 08/12/22 (309) at supper, 08/21/22 (195), 08/22/22 (195) and 08/23/22 (224). - No staff initials that indicate Insta-Glucose was administered for a blood sugar value of less than 60 on 08/05/22 (56), 08/08/22 (52), 08/09/22 (59) and 08/11/22 (54). Client #3 was unable to communicate effectively regarding his daily insulin needs due to his diagnoses of Autism, Severe IDD and due to his difficulty to understand questions and formulate responses.	V 118 V118.	Cnt'd - before lunch, and before dinner. Pay close Attention to the time of day you are administering units. The Scale for client #3 Is always located in Client #3's yellow insulin booklet and on His MAR • Wrong ~~unit~~ number of insulin administered. Staff should pay close Attention to the scale provided for correct units before breakfast, before lunch, and before dinner. and pay attn. to what time of day you are administering units - 1/12/23 • No Documentation of Additional units being Admin. on the back of the MAR the # of units that is Admin. when Blood sugar is 180 Always. Staff will Attend Medication Administration to ensure that guidelines are followed as well as procedures when administering meds, insulin & documentation as well as follow orders accurately and	1/12/23 1/12/23

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V 118	Continued From page 4 Interview on 08/23/22 staff #1 stated: - She had worked at the facility for approximately 9 months. - She had training regarding diabetes and insulin administration. - If client #3's blood sugar value is less than 60 staff would give him the insta-glucose. - Staff recheck client #3's blood sugar after the insta-glucose was administered. - Client #3 has a scale for administration of his insulin and she documented when insulin was given. - She had not had to call the physician for client #3's blood sugar above 400. Interview on 08/23/22 staff #2 stated: - He had worked at the facility for 3 years. - He had been trained in diabetes and insulin administration. - If client #3's blood sugar is less than 60 he gave the insta-glucose and provided some food. - He would then recheck client #3's blood sugar value. - He documented when insulin was given to client #3. Interview on 08/23/22 and 08/25/22 the Adult Day Services Manager/Qualified Professional (ADSM/QP) stated: - He often provided insulin to client #3 at lunch time during day services. - He understood staff should document correctly the amount of insulin administered. - He understood staff should document when the insta-glucose is given for blood sugar less than 60. - He created the document that was attached to client #3's August MAR to assist staff with the identification and administration of the proper	V 118	Contd Appropriately Training and Administration will also be provided for all the group home staff and QP. The training will be facilitated by BCDC-Contract Nurse, R.N. Training includes when to administer meds, how to administer, physician orders, Diabetes training, proper Nutritions, administering insulin, following correctly proper insulin and B/S readings + the scale. Document when insulin is given, etc. Following correct Plan of Correction + medication supervision	1/12/23 1/12/23

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V 118	Continued From page 5 insulin dosage at meal times. Review on 08/25/22 of a "Plan of Protection" signed by the ADSM/QP and dated 08/25/22 revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? Residential staff members will receive immediate feedback of findings and will receive immediate re-training on proper MAR documentation procedures. By Qualified Professional. Residential staff will also receive re-training on BCDC's (Beaufort County Developmental Center-Licensee) medication administration policy & procedures from a Registered Nurse (RN) within the next 30 days. Residential Manager will monitor MAR documentation daily for the 1st week to assure that meds (medications) are administered & documented correctly." - "Describe your plans to make sure the above happens. QP will meet with staff that is on-shift today, 8/25/22, to discuss the medication administration errors that were discovered. Proper MAR documentation procedures will be reviewed with staff on 8/25/22. For staff members not currently on shift (8/31/22). BCDC's contracted RN, [RN], will also re-train residential staff on BCDC's medication administration policy/procedure, with significant emphasis on the documentation of insulin administration when a sliding scale is involved, as well as documentation of PRN (as needed) meds." Client #3 was a 51 year old male with diagnoses of Autism Spectrum Disorder with Accompanying Intellectual and Language Impairment, Severe IDD and Insulin Dependent Diabetes Mellitus. Client #3's June 2022 thru August 2022 MARs had 16 episodes of no documentation of glucose	V 118 V118	QP met With staff that IS presently on shift to monitor and provide MEDICATION Supervision and PlAN of PlAN OF PROTECTION SPECIFICally with group Home #2 and Client #3 STAFF WILL PROVIDE PICS TO QP. each Time #3 IS ADMINISTERED His Insulin. Staff will	

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V 118	Continued From page 6 administered when blood sugar was less than 60, 19 episodes of no documentation extra insulin was administered as ordered, 8 episodes of the wrong number of units were administered as ordered and 2 episodes of no documentation the physician was notified when blood sugar was greater than 400. Although staff were able to state the specific parameters for client #3's physician orders for his diabetes, they failed to adequately document the information. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of client #3. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 118	Provide MAR. Fmt + Back for documentation purposes, Blood Sugar Log for client # 3 to show that correct protocol, and safety measures, documentation is being followed for 7 days. After 7 days the next shift will do the same for 7 days. Staff will also attend and participate Med ADMIN training. Nurse will also visit group homes at least monthly to check on medications, paperwork, documentation, etc.	1/12/23