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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey via desk review on 04/16/20 with an exit conferene via telephone on 04/24/20.	{D 000}	**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."**	**May 14, 202**
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A2 VIOLATION. The A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents (Resident #3) with fingerstick blood sugar readings (FSBS) outside of physician ordered parameters. The findings are: 1. Review of Resident #3's current FL2 dated 12/09/19 revealed: -Diagnoses included Type II diabetes mellitus. -There was an order to check FSBS twice daily (fasting and before administration of bedtime insulin). -There was an order for Levemir U-100 insulin, (a long acting insulin used to treat high blood sugar), inject 60 units every morning. Special instructions included hold for FSBS less than 100; notify the physician for FSBS less than 100 and greater than 300. Review of Resident #3's March 2020 electronic	{D 273}	**May 14, 202** **Retraining was completed for Medication Technicians on the process and procedure for communication and notification to Physicians related to any change in condition, to include, but not limited to, parameters for any Vital Sign or Blood Sugar out of range of set parameters. Retraining included the process for implementation and documentation of any new orders received as a result of the Physician notification. In addition, a Physician Notification form was implemented to ensure all Physician notifications and documentation are completed accurately as required. This process for communication and documentation, including use of communication log, will be utilized with all newly hired Med Techs.**	

Reviewed and acknowledged Sgk 06/16/2020

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{D 273}	Continued From page 1 Medication Administration Record (eMAR) revealed: -There was an entry for Levemir U-100 insulin, inject 60 units daily at 7:30am. Special instructions included hold for FSBS less than 100, notify the physician for FSBS less than 100 and greater than 300. -On 03/06/20, Resident #3's FSBS was documented as 98mg/dl. There was no documentation the physician was notified of the FSBS outside of ordered parameters. -On 03/11/20, Resident #3's FSBS was documented as 95mg/dl. There was no documentation the physician was notified of the FSBS outside of ordered parameters. -On 03/15/20, Resident #3's FSBS was documented as 95mg/dl. There was no documentation the physician was notified of the FSBS outside of ordered parameters. -On 03/17/20, Resident #3's FSBS was documented as 98mg/dl. There was no documentation the physician was notified of the FSBS outside of ordered parameters. -On 03/23/20, Resident #3's FSBS was documented as 98mg/dl. There was no documentation the physician was notified of the FSBS outside of ordered parameters. Review of Resident #3's April 2020 eMAR revealed: -There was an entry for Levemir U-100 insulin, inject 60 units every morning at 7:30am. Special instructions included hold for FSBS less than 100, notify the physician for FSBS less than 100 and greater than 300. -On 04/10/20, Resident #3's FSBS was documented as 92mg/dl. There was no documentation the physician was notified of the FSBS outside of ordered parameters. -On 04/16/20, Resident #3's FSBS was	{D 273}	**The Director of Resident Care/designee will review and monitor the completion of Physician Communication logs, Medication Administration Records and Resident Progress notes on a daily basis for 1 month, and then weekly thereafter, to ensure accurate completion as required.** **The Executive Director will conduct random audits to assist with compliance.**	

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{D 273}	Continued From page 2 documented as 97mg/dl. There was no documentation the physician was notified of the FSBS outside of ordered parameters. -On 04/19/20, Resident #3's FSBS was documented as 89mg/dl. There was no documentation the physician was notified of the FSBS outside of ordered parameters. Telephone interview with the first shift medication aide (MA) on 04/21/20 at 10:15am revealed: -She followed the insulin orders as shown on the eMAR. -She always checked the parameters as ordered by the physician. -If the FSBS was not within the ordered parameters, she notified the physician, documented the physician notification on the eMAR comment section, on the electronic progress notes and on the 24 hour shift to shift report. -She knew Resident #3 had parameters on her insulin administration. -She did not know why she documented Levemir 60 units was administered on 03/11/20 and 03/17/20 when the FSBS was outside of the ordered parameters. -She did not remember those specific dates, but she always held the insulin for Resident #3 when her FSBS was below 100 and notified the physician. -Sometimes when it was busy, she would forget to document a phone call to the physician. Telephone interview with another first shift MA on 04/22/20 at 2:30pm revealed: -She administered insulin to the residents on first shift. -If the insulin order had FSBS parameters, she would follow the parameters based on the FSBS reading.	{D 273}		

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{D 273}	Continued From page 3 -If the FSBS was below the parameters she would hold the insulin and she would notify the physician and the Resident Care Director (RCD). -She would document the hold and the reason, and the directive the physician gave after the phone call, in the electronic progress notes. -She did not know why on 03/04/20 and 03/12/20, she did not document Resident #3's FSBS was below 100, outside of the ordered parameters. -She did not know why she did not document in the electronic progress notes or comment section that she had notified the physician as ordered. Telephone interview with another first shift MA on 04/23/20 at 3:05pm revealed: -She started as a MA in March 2020. -In March she did not know how to document in the electronic progress notes. -She did not know how to document she had contacted the physician as ordered for FSBS below parameters on 03/18/20 and 03/26/20. -She thought she had notified the physician on 03/18/20 and 03/26/20, but did not document and did not remember informing the RCD. Telephone interview with Resident #3's primary care physician (PCP) on 04/22/20 at 2:05pm revealed: -He was the PCP for Resident #3 and had ordered Levemir U-100 insulin, inject 60 units every morning at 7:30am. Special instructions included hold for FSBS less than 100, notify the physician for FSBS less than 100 and greater than 300. -Staff had not notified him Resident #3's FSBS was less than 100, and this concerned him. -In managing Resident #3's diabetes, he monitored the morning and evening FSBS to evaluate insulin dosing. -His expectation was the staff would notify him as	{D 273}		

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{D 273}	Continued From page 4 ordered when FSBS parameters were less than 100. Telephone interview with Resident #3 on 04/22/20 at 3:15pm revealed: -Sometimes the MAs have a hard time locating her insulin, but she had never missed her morning or evening dose. -She could not remember feeling weak or dizzy after receiving her morning insulin. Telephone interview with the RCD on 04/23/20 at 3:30pm revealed: -It was the responsibility of the MAs to contact Resident #3's PCP if the FSBS was less than 100. -She could contact the PCP for the MAs if they were passing medications, and they requested her assistance. -She had not contacted Resident #3's PCP regarding FSBS below 100 in March or April. -She did not know the MAs had not documented contacting the PCP when Resident #3's FSBS was below 100. -There was no system in place for reviewing the eMARs to ensure proper documentation. -There was no system in place to review documentation of orders with parameters to ensure physicians were notified as ordered. -She did not audit the eMARs and review documentation of orders with parameters to ensure physicians were notified as ordered. -The MAs were not following the orders or the documentation process. Telephone interview with the Administrator on 04/23/20 at 3:55pm revealed: -The RCD was responsible for the MAs, their training and performance. -If a medication order had parameters, the MAs	{D 273}		

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{D 273}	Continued From page 5 should follow the instructions. -If the order included notification of the physician, it was the responsibility of the MAs to contact the physician. -The MAs should document the response of a physician contact in the electronic progress notes and comment section on the eMAR. -She did not know Resident #3's physician had not been contacted as ordered when her FSBS was below parameters.	{D 273}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	{D 367}		

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{D 367}	Continued From page 6	{D 367}		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the electronic Medication Administration Record(eMAR) was accurate for 1 of 5 sampled residents, (Resident #3), related to the administration of a blood pressure medication and a blood sugar medication.

The findings are:

1. Review of Resident #3's current FL2 dated 12/09/19 revealed diagnoses included Type II diabetes mellitus and hypertension.

a. Review of Resident #3's current FL2 dated 12/09/19 revealed:
-There was an order to check finger stick blood sugar (FSBS) twice daily (fasting and before administration of bedtime insulin).
-There was an order for Levemir U-100, (a long acting insulin to regulate blood sugar), inject 60 units every morning.
-Special instructions included; hold for FSBS less than 100, and notify the physician for FSBS less than 100 and greater than 300.

Review of Resident #3's March 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Levemir U-100 insulin, inject 60 units daily at 7:30am. Special instructions included hold for FSBS less than 100, notify the physician for FSBS less than 100 and

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{D 367}	Continued From page 7 greater than 300. -On 03/06/20, Resident #3's FSBS was documented as 98mg/dl and 60 units of Levemir was documented as administered. -On 03/11/20, Resident #3's FSBS was documented as 95mg/dl and 60 units of Levemir was documented as administered. -On 03/15/20, Resident #3's FSBS was documented as 95mg/dl and 60 units of Levemir was documented as administered. -On 03/17/20, Resident #3's FSBS was documented as 98mg/dl and 60 units of Levemir was documented as administered. -On 03/23/20, Resident #3's FSBS was documented as 98mg/dl and 60 units of Levemir was documented as administered. -On 03/06/20, 03/11/20, 03/15/20, 03/17/20 and on 03/23/20 60 units of Levemir insulin was documented as administered outside of the ordered FSBS parameters. Review of Resident #3's April 2020 eMAR revealed: -There was an entry for Levemir U-100 insulin, inject 60 units daily at 7:30am. Special instructions included; hold for FSBS less than 100, notify the physician for FSBS less than 100 and greater than 300. -On 04/10/20, Resident #3's FSBS was documented as 92mg/dl and 60 units of Levemir was documented as administered. -On 04/16/20, Resident #3's FSBS was documented as 97mg/dl and 60 units of Levemir was documented as administered. -On 04/19/20, Resident #3's FSBS was documented as 89mg/dl and 60 units of Levemir was documented as administered. -On 04/10/20, 04/16/20 and 04/19/20 60 units of Levemir insulin was documented as administered outside of the ordered FSBS parameters.	{D 367}		

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{D 367}	Continued From page 8 Telephone interview with a first shift medication aide (MA) on 04/21/20 at 10:15am revealed: -When administering insulin she checked the FSBS first. -She followed the insulin order as shown on the eMAR. -She checked the parameters as ordered by the physician. -If the FSBS was within those parameters, she administered the prescribed dosage of insulin. -If the FSBS was not within the parameters, she would notify the physician, document the notification on the eMAR comment section, the electronic progress notes and on the 24 hour shift to shift report. -She knew Resident #3 had parameters on her insulin administration. -She did not know why she documented Levemir 60 units was administered on 03/11/20 and 03/17/20 when the FSBS was outside of the ordered parameters. -She did not know why she did not document in the electronic progress notes or comment section the FSBS was below parameters ordered by the physician. -She always held the insulin for Resident #3 when her FSBS was below 100 and notified the physician as ordered. -Sometimes when it was busy, she would forget to document. Telephone interview with another first shift MA on 04/22/20 at 2:30pm revealed: -She administered insulin to the residents on first shift. -She referred to the medication orders on the eMAR. -If the insulin order had FSBS parameters, she would follow the parameters based on the FSBS	{D 367}		

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{D 367}	Continued From page 9 reading. -If the FSBS was below the parameters, she would hold the insulin and notify the physician and the Resident Care Director (RCD). -She would document the insulin was held and the reason in the electronic progress notes and contact the physician. -She would document the directive given by the physician in the electronic progress note as well. -She would also make an entry in the eMAR comments. -She documented on the eMAR when medications were not administered, including the reason. -She did not know why on 03/04/20 and 03/12/20, she documented Resident #3 was administered Levemir insulin when the FSBS was outside the ordered parameters. -She did not remember why she had not documented in the electronic progress notes or comment section the FSBS was below parameters or that she had contacted the physician. Telephone interview with a subsequent first shift MA on 04/23/20 at 3:05pm revealed: -She was employed as a MA in March of 2020. -She reported to the Resident Care Director (RCD) as her direct supervisor. -The Regional Registered nurse (RN) had trained her on documentation on the eMAR. -The RCD assisted her in documenting on the eMAR when she had questions. -She did not know how to document in the electronic progress notes when there were exceptions. -She did not know how to document when a medication was not administered. -On 03/18/20 and 03/26/20, she did not administer insulin to Resident #3 based on her	{D 367}		

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{D 367}	Continued From page 10 FSBS, but did not know to document on the electronic progress note. -She thought she had reported to the physician Resident #3's FSBS was below 100, but did not know how to document the call in the electronic progress notes. -She reported the error to the RCD and she "fixed it". Telephone interview with the RCD on 04/23/20 at 3:30pm revealed: -She was responsible for ensuring MAs administered medications as ordered and documented accurately. -The facility did not have a written policy on documentation. -She instructed the MAs to document in the electronic progress notes if they did not administer medications or any exceptions to medication administration. -She did not audit eMARs for completed documentation or accurate documentation. -There was no system in place to routinely audit FSBS values documented on the eMAR compared to insulin administration. -There was no process for reviewing the eMARs to ensure proper documentation. -There was no process to review documentation of orders with parameters to ensure medication was administered within physician orders. -The MAs were not following the process for documentation and administration of insulin parameters as they have identified during their interviews. Telephone interview with the Administrator on 04/23/20 at 3:55pm revealed: -The RCD was responsible for the MAs, their training and performance. -The RCD trained the MAs on the eMAR system.	{D 367}		

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{D 367}	Continued From page 11 -If a medication was not administered to a resident, the documentation on the eMAR should show parenthesis around the MAs initials. -If a medication was not administered, the MAs have been instructed to document in the comment section and the electronic progress note. -The Administrator's expectation was that the RCD would review the eMARS regularly for proper medication administration and documentation. -The facility did not have a policy on documentation. They followed the "regulatory statutes" for documentation. -She did not know the MAs were not documenting exceptions to medication administration, and contact with physicians as ordered. b. Review of Resident #3's current FL2 dated 12/09/19 revealed: -There was an order for Metoprolol Succinate, extended release tablet, 25mg daily with special instructions to check and record pulse and hold the Metoprolol if Resident #3's pulse was less than 60. Review of Resident #3's March 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Metoprolol Succinate, extended release tablet, 25mg, to be administered daily at 8:00am. -Special instructions included: hold Metoprolol for a pulse of less than 60. -On 03/04/20, Resident #3's pulse was documented as 55 and Metoprolol Succinate 25mg was documented as administered. -On 03/07/20, Resident #3's pulse was documented as 55 and Metoprolol Succinate 25mg was documented as administered.	{D 367}		

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{D 367}	Continued From page 12 -On 03/12/20, Resident #3's pulse was documented as 53 and Metoprolol Succinate 25mg was documented as administered. -On 03/18/20, Resident #3's pulse was documented as 53 and Metoprolol Succinate 25mg was documented as administered. -On 03/20/20, Resident #3's pulse was documented as 57 and Metoprolol Succinate 25mg was documented as administered. -On 03/28/20, Resident #3's pulse was documented as 55 and Metoprolol Succinate 25mg was documented as administered. -On 03/04/20, 03/07/20, 03/12/20, 03/18/20, 03/20/20 and 03/28/20, Metoprolol Succinate was documented as administered to Resident #3 outside of the ordered pulse parameters. Telephone interview with a first shift medication aide (MA) on 04/21/20 at 10:15am revealed: -When administering medications she followed the orders as written on the eMAR. -If parameters were ordered before administering a medication, she would check the parameters. -She knew Resident #3 had parameters on her blood pressure medication (Metoprolol Succinate). -If Resident #3's pulse was below 60, she did not administer the medication. -She would document why she held the medication in the electronic progress note. -She caught herself several times documenting, (checking the administered box on the eMAR), that she had administered the Metoprolol to Resident #3 when she had not. -She did not document in the electronic progress notes or the comment box that she had made an error in documentation, or had held the medication. -She does not remember notifying her supervisor of the error in documentation.	{D 367}		

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(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
{D 367}	Continued From page 13 Telephone interview with another first shift MA on 04/23/20 at 3:05pm revealed: -When she administered medications to residents with parameters ordered, she took the vital signs. -If the vital signs were below parameters, she did not administer the medication and notified the physician. -She documented in the electronic progress notes the reason the medication was not administered and the physician's recommendations. -In March she did not know how to document in the electronic progress notes when there were exceptions. -She did not know how to document when a medication was not administered. -She did not know how to document contact with a physician in the electronic progress notes. -She reported the error to the Resident Care Director (RCD), and the RCD "fixed it". -She would not administer Metoprolol to Resident #3 if her pulse was less than 60. Telephone interview with the RCD on 04/23/20 at 3:30pm revealed: -The MAs received initial training on the eMAR system from the previous Regional Registered nurse (RN). -The RCD would assist the MAs with eMAR issues once they were checked off to administer medications. -She could go in to the eMAR system and correct an error the MAs had with documentation. -She did not remember a time it was necessary to make a correction in the eMAR documentation since January 2020 or before. -There was no system in place to review documentation of orders with parameters to ensure medication was administered within	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023045	A. BUILDING: _____ B. WING _____	R 04/24/2020

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{D 367}	Continued From page 14 physician orders. Telephone interview with the Administrator on 04/23/20 at 3:55pm revealed: -The RCD trained the MAs on the eMAR system. -If a medication was not administered, the MAs had been instructed to document in the comment section and the electronic progress note. -The Administrator's expectation was that the RCD would review the eMARS regularly for proper medication administration and documentation. -She did not know the MAs were not documenting exceptions to medication administration and contact with the resident's physicians.	{D 367}		