STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL084001	A. BUILDING: _____ B. WING _____	C 11/04/2021

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THE TAYLOR HOUSE	319 PALMER STREET ALBEMARLE, NC 28001

(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 000	Initial Comments The Adult Care Licensure Section and the Stanly County Department of Social Services conducted an annual survey on 11/03/21 to 11/04/21.	D 000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider for 3 of 4 sampled residents (#1, #2, and #4) related to fingerstick blood sugar (FSBS) results less than 60 (#2), abnormal urinary symptoms and discomfort (#4), elevated FSBS results (#1); and not obtaining ordered laboratory tests for 2 of 4 sampled residents (#2, #4) related to valproic acid levels (#2, #4) and a basic metabolic panel (#4). The findings are: 1. Review of Resident #2's current FL2 dated 08/19/21 revealed diagnoses included diabetes mellitus type 2 and dementia. a. Review of Resident #2's current FL2 dated 08/19/21 revealed: -There was an order for Novolog insulin (used to control blood sugar) administer via sliding scale; if fingerstick blood sugar (FSBS) below 100 administer 0 units; 101-119= 2 units, 120-140=4 units, 141-170-6 units, 171-200=8 units, 201-250=10 units, 251-30=12 units, 301-350=14	D 273	On 11/04/21, primary care providers of all residents with an order for FSBS were contacted and asked to sign an order with perimeters for blood sugar readings and guidelines to follow with out-of-range readings. Orders were implemented upon receipt. On 11/05/21, Resident #2 received a new order for blood sugar checks 4 times a day with guidelines for blood sugar readings out of range (low and high). The guidelines state for blood sugars reading below 80, contact PEC triage. If below 60, give 8 ounces of orange juice. For blood sugar reading above 350, contact PEC triage. Print weekly blood sugar readings on Friday morning. A new order for a Valproic acid level for Resident #2 was received on 11/04/21. The valproic acid level was drawn on 11/05/21. Resident #4 was evaluated by their primary care provider on 11/05/21 for her urinary symptoms. A new order for a urinalysis with culture and susceptibility for resident #4 was signed on 11/05/21. The urine specimen was obtained on 11/06/21. A new order for a Valproic acid level for Resident #4 was received on 11/05/21. The Valproic acid level was drawn on 11/06/21.	12/06/2021

Reviewed and Acknowledged
Date: 12/06/21
CS

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D 273	Continued From page 1 units, 351-400=16 units, 401 or above administer 18 units and notify the primary care provider (PCP). -There was an order for blood sugar readings below 60mg/dl, administer 6 oz. orange juice and notify the PCP. -There was an order for Levemir (used to control blood sugar) 100 units/ml 22 units every morning, hold if FSBS reading below 70. -There was an order for Levemir 100 units/ml 31 units daily at bedtime, hold if FSBS reading below 70. Review of Resident #2's PCP order dated 10/22/21 revealed: -Discontinue levemir 31 units daily at bedtime. -Levemir 28 units daily at bedtime. Review of Resident #2's September 2021 electronic Medication Administration Record (eMAR) revealed: -There were entries for FSBS four times a day scheduled at 7:00am, 11:00am, 4:00pm, and 8:00pm. -On 09/09/21 at 4:00pm the documented FSBS was 51. -On 09/10/21 at 4:00pm the documented FSBS was 52. -On 09/12/21 at 4:00pm the documented FSBS was 56. -On 09/13/21 at 11:00am the documented FSBS was 42. -On 09/17/21 at 7:00am the documented FSBS was 55. Review of Resident #2's September 2021 electronic progress notes dated 09/09/21 to 09/17/21 revealed: -There was an entry on 09/09/21 at 6:14pm, Resident #2's blood sugar was 51 before supper,	D 273	The policy for blood sugar checks was updated by the Administrator and Vice President of Clinical Services on 11/29/21. The Administrator reviewed the updated policy with the primary care provider, which approved the facility's updated policy for monitoring blood sugar checks and notification of primary care provider if the blood sugar is out of range (high or low). All residents with orders for blood sugar checks will have a standing order on their Medication Administration Record with guidelines for reporting blood sugar readings out of range (high or low) as specified by each Primary Care Provider.	

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D 273	Continued From page 2 the resident ate about 20% of supper, the medication aide (MA) rechecked the FSBS after dinner and it was 164. -There was no documentation of the PCP being notified of the FSBS value of 51. -There was no additional documentation of interventions made or notification of the PCP for the low FSBS values on 09/10/21 at 4:00pm, on 09/12/21 at 4:00pm, 09/13/21 at 11:00am, or 09/17/21 at 7:00am. Review of Resident #2's October 2021 eMAR revealed: -There were entries for FSBS four times a day scheduled at 7:00am, 11:00am, 4:00pm, and 8:00pm. -On 10/06/21 at 7:00am the documented FSBS was 52. -On 10/13/21 at 7:00am the documented FSBS was 53. Review of Resident #2's October 2021 electronic progress notes dated 10/06/21 to 10/13/21 revealed: -There was an entry on 10/13/21 at 6:35am, Resident #2's blood sugar was 53 this morning, 2 cups of orange juice were given to the resident, the MA will recheck FSBS in 30 minutes. -There was no documentation of the PCP being notified of the FSBS value of 53. -There was no additional documentation of interventions made or notification of the PCP for the low FSBS value on 10/06/21 at 7:00am. Interview with the Administrator on 11/03/21 at 3:30pm revealed: -Resident #2's PCP was in the facility every week. -The PCP reviewed Resident #2's FSBS results. -The MAs should have notified the PCP when the FSBS were less than 60.	D 273	The Pharmacy Nurse Consultant will conduct a training on 12/16/21 to review the following topics: Diabetes Monitoring and signs and symptoms of Diabetic distress. All Medication Aides will be required to attend the training. All Medication Aides were re-educated by the Administrator on 11/05 and 11/06/2021 on the procedure for reviewing new orders, transcribing orders to the medication administration record, and reporting new orders to the appropriate third party vendor (home health or lab) when applicable. All Medication Aides were re-educated by the Administrator on 11/05 and 11/06/2021 on the procedure for documenting reported symptoms in the medical record and reporting resident symptoms to their primary care provider for further guidance. The Administrator or designee performs weekly audit on all residents with orders for blood sugar checks for 6 weeks to ensure the blood sugar checks were completed as ordered, results are documented in the medical record, and any out of range results were reported to the primary care provider. The Administrator or designee will audit all new orders weekly for 6 weeks to ensure orders were transcribed to the medication administration record, reported to the third party vendor (home health and/or lab) when applicable, and completed as ordered. The Administrator or designee will conduct 3 resident interviews per week for 6 weeks to ensure any reported symptoms were documented in the resident's medical record and reported to the resident's primary care provider.	

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D 273	Continued From page 3 -The MAs received diabetic training annually. Interview with the Administrator on 11/04/21 at 9:10am revealed: -Resident #2 had an order to give 6 oz. orange juice and notify the PCP for FSBS less than 60. -She had been unable to find any documentation where staff had notified the PCP of Resident #2's FSBS less than 60 in September and October 2021. Interview with a MA on 11/04/21 at 11:35am revealed: -The PCP should be notified when a resident's FSBS was less than 60. -She documented PCP contacts in the resident's electronic medical record. Telephone interview with a second MA on 11/04/21 at 12:12pm revealed: -She had performed Resident #2's FSBS on 09/10/21 and 09/12/21 and documented the low FSBS values of 52 on 09/10/21 and the 56 on 09/12/21. -She had not called the PCP or triage service to notify them of these low FSBS. -The routine procedure to notify the PCP would have been to leave a note in the PCP folder in the medication cart for the resident to be seen by the PCP on their weekly visit to the facility. -She did not leave a note for the PCP about Resident #2's low blood sugar results. -She did speak with Resident #2's PCP on 10/22/21 to let her know the resident had been experiencing low blood sugar levels. -The PCP had written an order on 10/22/21 to decrease Resident #2's long acting insulin on that day. -She did follow the low blood sugar parameters and give the resident juice or a snack for a low	D 273	The Administrator or designee will monitor the followings audits: 1.Ensuring blood sugar checks are completed as ordered and out of range results are reported to the primary care provider. 2.New orders are transcribed, reported to third party vendors (home health and/or lab) when applicable, and completed as ordered. 3.Ensuring resident reported symptoms are documented and reported to the primary care provider. Audits will be completed weekly for 6 weeks. Any deficiencies noted will be addressed immediately and corrective action taken as necessary. The Administrator will assess and modify the plan of correction as needed to ensure continued compliance.	

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blood sugar.

Telephone interview with Resident #2's PCP on 11/04/21 at 10:15am revealed:
-She had not been notified of any of Resident #2's FSBS readings less than 60 in September and October 2021.
-The staff may have contacted the triage service and notified an on-call provider, but she had did not have access to that information.
-She expected staff to call if Resident #2's FSBS was less than 60.
-FSBS in the 40's and 50's could cause symptoms such as nausea, confusion, diaphoresis, and a decline in mental alertness.
-Those symptoms could be mild or severe depending upon the resident's personal history of low blood sugars.
-Low blood sugar levels could require a hospital visit to treat or could result in a coma.

Telephone interview with the primary care provider's triage service on 11/04/21 at 2:07pm revealed there was no record of the on-call provider's service being notified of Resident #2's FSBS's of less than 60 on 09/09/21, 09/10/21, 09/13/21, 09/17/21, 10/06/21, and 10/13/21.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

b. Review of Resident #2's Primary Care Provider (PCP) order dated 10/15/21 revealed valproic acid level (blood test used to test the amount of valproic acid in the blood to determine whether the drug concentration is within therapeutic range) to be completed the week of 10/25/21.

Review of Resident #2's laboratory test results

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revealed there were no results for a valproic acid level dated the week of 10/25/21.

Interview with a medication aide (MA) on 11/04/21 at 11:35am revealed:
-Resident #2's valproic acid level was not completed the week of 10/25/21 as ordered.
-Resident #2 was under the care of a home health nursing service.
-Staff had failed to notify the home health service of the order for the valproic acid level.
-The MAs were responsible for sending orders for labs to the home health service.
-The MAs were responsible for making a "notification note" in the electronic Medication Administration Record (eMAR) system to remind the MAs to "look out" for returning lab results for a resident.
-The MAs knew a lab had been completed when they received the results.
-The MAs received a verbal shift report at change of shift and outstanding labs would be information shared during shift report.

Interview with the Administrator on 11/04/21 at 9:10am revealed:
-The valproic acid level ordered to be done the week of 10/25/21 for Resident #2 had not been completed.
-The MA had not followed through with sending the order to the home health nursing service.
-Resident #2 had home health nursing services and they would have drawn the valproic acid level if they had known about the order.
-The home health nursing service required a new order to now obtain a valproic acid level for the resident.
-She was getting a new order today (11/04/21) from Resident #2's PCP for a valproic acid level.

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Telephone interview with Resident #2's PCP on 11/04/21 at 10:05am revealed:
-The facility had contacted her that morning (11/04/21) to request a new order for a valproic acid level for Resident #2.
-She had not known the valproic acid was not obtained during the week of 10/25/21 as ordered until the call from facility staff on 11/04/21.
-There was "possibly no outcome" to Resident #2 for the valproic level being delayed.
-Resident #2 was prescribed a low dose of valproic acid.
-The valproic acid levels were ordered periodically to ensure the correct dosage of medication was being administered to the resident.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

2. Review of Resident #4's current FL2 dated 06/30/21 revealed diagnoses included atrial fibrillation and anxiety.

a. Interview with Resident #4 on 11/03/21 at 9:49am revealed:
-She had urinary tract infections (UTIs) often and thought she had one currently.
-She told several facility staff and the staff said "don't tell us" and informed her to tell the primary care provider (PCP) when they came to visit at the facility.
-It had been "over a week" since she told staff she experienced urinary frequency with pain and a burning sensation upon urination and "I am miserable".

Review of Resident #4's PCP orders revealed:
-There were no orders for evaluation or treatment

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of Resident #4's urinary symptoms.
-There was no documentation of notification of Resident #4's PCP to report abnormal urinary symptoms.

Interview with the Administrator on 11/03/21 at 4:55pm revealed:
-Resident #4 complained "a lot" of symptoms of UTI.
-Resident #4's PCPs would check with the resident when they were in the facility to ask more in depth questions about the resident's symptoms.
-Once the PCP evaluated the resident's symptoms the PCP would decide if the resident needed lab testing or medications to treat.

Telephone interview with the Clinical Manager from Resident #4's home health service on 11/04/21 at 9:29am revealed:
-Resident #4 had reported urinary frequency and burning with urination to the home health nurse (HHN) during a visit on 10/27/21.
-The HHN had notified facility staff of the resident's complaint of increased urinary frequency and burning with urination.
-Facility staff told the HHN they would notify Resident #4's PCP of the resident's urinary symptoms at the PCP's next visit.
-The PCP would be in the facility to see residents on 10/29/21.

Interview with the Administrator on 11/04/21 at 9:40am revealed:
-Resident #4 was not seen by the PCP on 10/29/21.
-Resident #4's complaints of increased urinary frequency and burning with urination should have been documented by a medication aide (MA) in a note and placed in the PCP communication folder

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located on the medication cart.
-The PCP went through the folder on their weekly visits to the facility.
-The HHN was also allowed to leave written communication of resident health concerns in the folder for the PCP.
-She had looked in the PCP communication folder and could not find any written communication concerning Resident #4's complaints of urinary symptoms.

Telephone interview with a MA on 11/04/21 at 12:12pm revealed:
-She had been the MA assigned to care for Resident #4 on 10/27/21 when the HHN visited Resident #4.
-The HHN had not reported Resident #4's complaints of increased urinary frequency and burning with urination to her.
-Resident #4 had not complained of any abnormal urinary symptoms to her.
-No other staff had reported Resident #4's complaints of urinary symptoms to her.

Telephone interview with Resident #4's PCP on 11/04/21 at 10:05am revealed:
-She had visited the facility to see residents on 10/29/21.
-She did not recall staff reporting Resident #4's complaints of increased urinary frequency and burning with urination.
-She felt Resident #4 would tell staff if she had a concern.
-She would have expected staff to report Resident #4's urinary symptoms and discomfort to their triage service rather than waiting until 10/29/21 for a PCP onsite visit.
-The triage service provided access to on-call health care providers 24 hours a day/7 days a week.

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-Urinary symptoms of increased frequency and burning with urination were not necessarily due to infection.
-Resident #4 would need to be evaluated to determine the cause.
-Delayed treatment of a urinary infection could lead to a need for prolonged antibiotic treatment and could lead to hospitalization.

b. Review of Resident #4's Primary Care Provider (PCP) order dated 10/15/21 revealed Basic Metabolic Panel (BMP) (a blood test that measures eight different substances in the blood) for elevated sodium in week of 10/18/21.

Review of Resident #4's laboratory test results revealed there were no results for a BMP dated the week of 10/18/21.

Interview with a medication aide (MA) on 11/04/21 at 11:35am revealed:
-Resident #4's BMP was not completed the week of 10/18/21 as ordered.
-Resident #4 was under the care of a home health nursing service.
-Staff had failed to notify the home health service of the lab order for the BMP.
-The MAs were responsible for sending orders for labs to the home health service.
-The MAs were responsible for making a "notification note" in the electronic Medication Administration Record (eMAR) system to remind the MAs to "look out" for returning lab results for a resident.
-The MAs knew a lab had been completed when they received the results.
-The MAs received a verbal shift report at change of shift and outstanding labs would be information shared during shift report.

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Interview with the Administrator on 11/04/21 at 9:10am revealed:
-The BMP ordered to be done the week of 10/18/21 for Resident #4 had not been completed.
-The MA had not followed through with sending the order to the home health nursing service.
-Resident #4 had home health nursing services and they would have drawn the BMP if they had known about the order.
-The home health nursing service required a new order to obtain the BMP for the resident.
-She was getting a new order today (11/04/21) from Resident #4's PCP for a BMP.

Telephone interview with Resident #4's PCP on 11/04/21 at 10:05am revealed:
-The facility had contacted her that morning (11/04/21) to request a new order for a BMP for Resident #4.
-She had not known the BMP was not obtained during the week of 10/18/21 until the call from facility staff on 11/04/21.
-She could not remember if the BMP was ordered for routine monitoring or for monitoring of an abnormal value.
-If the BMP was for routine monitoring, there was probably no adverse outcome to the resident for the BMP having been delayed.

c. Review of Resident #4's Primary Care Provider (PCP) order dated 10/15/21 revealed there was an order for a valproic acid level (blood test used to test the amount of valproic acid in the blood to determine whether the drug concentration is within therapeutic range) to be completed the week of 10/25/21.

Review of Resident #4's laboratory test results revealed there were no results for a valproic acid

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level dated the week of 10/25/21.

Interview with a medication aide (MA) on 11/04/21 at 11:35am revealed:
-Resident #4's valproic acid level was not completed the week of 10/25/21 as ordered.
-Resident #4 was under the care of a home health nursing service.
-Staff had failed to notify the home health service of the order for the valproic acid lab.
-The MAs were responsible for sending orders for labs to the home health service.
-The MAs were responsible for making a "notification note" in the electronic Medication Administration Record (eMAR) system to remind the MAs to "look out" for returning lab results for a resident.
-The MAs knew a lab had been completed when they received the results.
-The MAs received a verbal shift report at change of shift and outstanding labs would be information shared during shift report.

Interview with the Administrator on 11/04/21 at 9:10am revealed:
-The valproic acid level ordered to be done the week of 10/25/21 for Resident #4 had not been completed.
-The MA had not followed through with sending the order to the home health nursing service.
-Resident #4 had home health nursing services and they would have drawn the valproic acid level if they had known about the order.
-The home health nursing service required a new order to obtain a valproic acid level for the resident.
-She was getting a new order today (11/04/21) from Resident #4's PCP for a valproic acid level.

Telephone interview with Resident #4's PCP on

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	HAL084001	A. BUILDING: _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOUSE	319 PALMER STREET ALBEMARLE, NC 28001

(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 273	Continued From page 12 11/04/21 at 10:05am revealed: -The facility had contacted her that morning (11/04/21) to request a new order for a valproic acid level for Resident #4. -She had not known the valproic acid was not obtained during the week of 10/25/21 as ordered until the call from facility staff on 11/04/21. -There was "possibly no outcome" to Resident #4 for the valproic level being delayed. -Resident #4 was prescribed a low dose of valproic acid. -The valproic acid levels were ordered periodically to ensure the correct dosage of medication was being administered to the resident. 3. Review of Resident #1's current FL-2 dated 12/14/20 revealed: -Diagnoses included type 2 diabetes mellitus and dementia. -There was a physician's order to check fasting finger stick blood sugars (FSBS) every morning and no parameters were ordered to notify the primary care provider (PCP). Review of the facility's contracted home health progress note for Resident #1 dated 10/29/21 revealed a diagnoses of type 2 diabetes mellitus with hyperglycemia and a comment that read "symptoms controlled with difficulty, affecting daily functioning, patient needs ongoing monitoring." Review of Resident #1's September 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for fasting FSBS daily at 7:00am. -FSBS were documented daily ranging from 121 through 205.	D 273		

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D 273	Continued From page 13 Review of Resident #1's October 2021 eMAR revealed: -There was an entry for fasting FSBS daily at 7:00am. -FSBS were documented daily from 10/01/21 through 10/31/21 ranging from 69 through 348. -On 10/17/21 at 7:00am the documented FSBS was 218. -On 10/18/21 at 7:00am the documented FSBS was 215. -On 10/19/21 at 7:00am the documented FSBS was 193. -On 10/20/21 at 7:00am the documented FSBS was 214. -On 10/21/21 at 7:00am the documented FSBS was 243. -On 10/22/21 at 7:00am the documented FSBS was 251. -On 10/23/21 at 7:00am the documented FSBS was 324. -On 10/24/21 at 7:00am the documented FSBS was 308. -On 10/25/21 at 7:00am the documented FSBS was 348. -On 10/28/21 at 7:00am the documented FSBS was 255. -On 10/29/21 at 7:00am the documented FSBS was 230. -On 10/30/21 at 7:00am the documented FSBS was 242. -On 10/31/21 at 7:00am the documented FSBS was 265. -There was no documentation of notification to the PCP of the elevated FSBS levels from 10/17/21 through 10/31/21. Review of Resident #1's November 2021 eMAR revealed: -There was an entry for fasting FSBS daily at 7:00am.	D 273		

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D 273	Continued From page 14 -On 11/01/21 at 7:00am the documented FSBS was 280. -On 11/02/21 at 7:00am the documented FSBS was 502. -On 11/03/21 at 7:00am the documented FSBS was 360. -There was no documentation of notification to the PCP of the elevated FSBS levels. Interview with the Administrator on 11/04/21 at 9:20am revealed: -The diabetic residents were supposed to have an order to treat low or elevated FSBS and parameters with details of when to notify the PCP. -The MAs were supposed to notify the resident's PCP of low or elevated FSBS to receive orders for treatment. -Diabetic training was provided by the facility annually and staff knew the normal ranges for FSBS levels. -She did not know the normal ranges for FSBS levels and would need to clarify the ranges with the PCP and ask the PCP when the facility should notify them of abnormal FSBS. -Staff only call the PCP when there was an order to call for notification of abnormal FSBS. -The PCP visits the facility weekly and saw residents that the MA had concerns about. -The MAs would leave a note in a folder for the PCP about any resident concerns. -She could not find a note to the PCP about Resident #1's FSBS being elevated. -There was no documentation on the eMAR Resident #1's PCP was notified of a FSBS reading of 502 on 11/02/21. Telephone interview with the PCP on 11/04/21 at 10:05am revealed: -The facility should have a policy related to when to notify the PCP of a residents low or elevated	D 273		

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D 273	Continued From page 15	D 273		

FSBS.
-She gave orders for parameters when she ordered insulin for residents but Resident #1 did not have insulin ordered.
-She was not notified Resident #1's FSBS were elevated since mid-October and was 502 on 11/02/21.
-She expected the facility staff to contact her when Resident #1's FSBS was 502 on 11/02/21 or with any FSBS outside normal ranges.
-Resident #1 could experience acute vision changes, confusion, change in mental status, damage to organs, blindness, poor circulation, kidney damage, and possible amputation with elevated FSBS over time.

Interview with a MA on 11/04/21 at 11:35am revealed:
-When a resident had an abnormal FSBS and if no parameters were provided by the PCP, she would call to notify the PCP and receive orders for treatment.
-A low FSBS reading would range from 40-60 depending on the residents normal FSBS reading.
-A high FSBS reading would be a reading of 300 or greater and she would notify the PCP.
-She did not work on 11/02/21 when Resident #1's FSBS reading was 502 and could not find any documentation on the eMAR that Resident #1's PCP was notified.
-Resident #1's FSBS reading this morning (11/04/21) at 7:00am was 446 and she rechecked Resident #1's FSBS an hour later and got a reading of 397.
-She called and notified Resident #1's PCP of the elevated FSBS and documented a comment in the eMAR of the PCP notification.

Telephone interview with a second MA on

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D 273	Continued From page 16 11/04/21 at 12:07pm revealed: -She worked on 11/02/21 and checked Resident #1's FSBS with a reading of 502. -Resident #1 had refused her bedtime dose of diabetic medication on 11/01/21 and she thought that was the reason Resident #1's FSBS was 502 on 11/02/21. -She noticed Resident #1's FSBS were elevated since she was admitted to the hospital in October 2021 with a urinary tract infection and dehydration. -She did not call Resident #1's PCP to notify her Resident #1's FSBS was 502 on 11/02/21 because Resident #1 did not have parameters to call for abnormal FSBS levels. -She did not know what to do if a resident's FSBS was low or high and there were no ordered parameters because she did not recall it being covered in diabetic training. -She had diabetic training about a year ago. Attempted interview with Resident #1 on 11/03/21 at 3:30pm was unsuccessful. _____ The facility failed to notify the primary care provider of seven FSBS in the 40's and 50's in September 2021 and October 2021 for Resident #2 and abnormal urinary symptoms and discomfort for Resident #4 which could result in an increased risk for hospitalization and coma (#2) and an increased risk of prolonged antibiotic treatment and hospitalization (#4) which was detrimental to health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/04/21. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER	D 273		

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D 273	Continued From page 17 19, 2021.	D 273		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider for 3 of 4 sampled residents (#1, #2, and #4) related to fingerstick blood sugar (FSBS) results less than 60 (#2), abnormal urinary symptoms and discomfort (#4), elevated FSBS results (#1); and not obtaining ordered laboratory tests for 2 of 4 sampled residents (#2, #4) related to valproic acid levels (#2, #4) and a basic metabolic panel (#4). [Refer to tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912	All staff have reviewed resident rights with emphasis on providing adequate and appropriate resident care in compliance with state and federal regulations and rules. Audits performed for D 273* every week for six weeks will show resident rights are followed in accordance to state guidelines. * The Administrator or designee will monitor the followings audits: 1.Ensuring blood sugar checks are completed as ordered and out of range results are reported to the primary care provider. 2.New orders are transcribed, reported to third party vendors (home health and/or lab) when applicable, and completed as ordered. 3.Ensuring resident reported symptoms are documented and reported to the primary care provider. Audits will be completed weekly for 6 weeks. Any deficiencies noted will be addressed immediately and corrective action taken as necessary. The Administrator will assess and modify the plan of correction as needed to ensure continued compliance.	12/06/2021