STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HENDERSON CARE CENTER	125 HENDERSON CIRCLE FOREST CITY, NC 28043

(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 conducted an annual survey and complaint investigation on 06/30/22 to 07/01/22.	D 000		
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 interviews and record review, the facility failed to send blood sugar (BS) log results for 1 of 2 sampled resident (Resident #3) with orders for blood sugar checks and insulin. The findings are: Review of Resident #3's current FL2 dated 04/13/22 revealed: -Diagnoses included hyperglycemia (an excess of glucose in the bloodstream, often associated with diabetes mellitus). -There was an order for Novolog (a rapid acting insulin used to lower blood glucose) Flexpen 100 unit/ml 7 units before breakfast give with sliding scale: 150-199=1 unit, 200-249=2 units, 250-299=3 units, 300-349=4 units, 350-399=5 units, 400 or greater= 6 units, hold if blood sugar (BS) is below 80. -There was an order for Novolog Flexpen 100 unit/ml 7 units before lunch give with sliding scale: 150-199=1 unit, 200-249=2 units, 250-299=3 units, 300-349=4 units, 350-399=5 units, 400 or greater= 6 units, hold if blood sugar	D 273		

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is below 80.
-There was an order for Novolog Flexpen 100 unit/ml 10 units before supper give with sliding scale: 150-199=1 unit, 200-249=2 units, 250-299=3 units, 300-349=4 units, 350-399=5 units, 400 or greater= 6 units, hold if blood sugar is below 80.
-There was an order for Lantus (a long acting insulin used to lower blood glucose) 100 unit/ml 18 units every morning.
-There was an order for Lantus 100 unit/ml 10 units daily at bedtime.

Review of Resident #3's Endocrinology Physician's Assistant (PA) orders dated 04/20/22 revealed:
-There was an order for Novolog Flexpen 100 unit/ml 5 units before breakfast, 5 units before lunch, and 8 units before supper, give with sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5 units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units, hold only if blood sugar is below 80.
-There was an order for Lantus 100 unit/ml 16 units every morning.
-There was an order for Lantus 100 unit/ml 8 units daily at bedtime.
-Check BS before meals and before bed, please bring your meter to all appointments.
-Follow-up with Endocrinologist in 3 months.
-Send blood glucose logs in 2 weeks for review/insulin adjustment.

Review of Resident #3's April 2022 BS logs dated 04/21/22 to 04/30/22 revealed:
-The resident's BS were checked four times a day as ordered scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm.
-On 04/30/22 at 4:30pm, the BS was 41.

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D 273	Continued From page 2 -The BS range was 41 to 368. Review of Resident #3's May 2022 BS logs dated 05/01/22 to 05/31/22 revealed: -The resident's BS were checked four times a day as ordered scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm. -On 05/01/22 at 11:30am, the BS was 42. -On 05/04/22 at 11:30am, the BS was 59. -On 05/05/22 at 11:30am, the BS was 64. -On 05/08/22 at 6:30am, the BS was 65. -On 05/23/22 at 6:30am, the BS was 47. -On 05/27/22 at 6:30am, the BS was 57. -On 05/30/22 at 6:30am, the BS was 74. -The BS range was 42-407. Review of Resident #3's record revealed there was no documentation the BS logs were sent to the Endocrinologist for review as ordered on 04/20/22. Review of Resident #3's June 2022 Insulin Administration Logs dated 06/01/22 to 06/30/22 revealed: -The resident's BS were checked four times a day as ordered scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm. -On 06/02/22 at 6:30am, the BS was 60. -On 06/03/22 at 6:30am, the BS was 55. -On 06/04/22 at 8:00pm, the BS was 77. -On 06/08/22 at 11:30am, the BS was 66. -On 06/09/22 at 6:30am, the BS was 63. -On 06/11/22 at 8:00pm, the BS was 63. -On 06/15/22 at 11:30am, the BS was 61. -On 06/17/22 at 4:30pm, the BS was 55. -On 06/17/22 at 8:00pm, the BS was 55. -On 06/19/22 at 11:30am, the BS was 59. -On 06/21/22 at 6:30am, the BS was 29. -On 06/22/22 at 4:30pm, the BS was 77. -On 06/22/22 at 6:30am, the BS was 66.	D 273		

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-On 06/25/22 at 4:30pm, the BS was 52.
-On 06/26/22 at 6:30am, the BS was 63.
-On 06/28/22 at 6:30am, the BS was 44.
-The BS range was 29-453.

Review of Resident #3's record revealed there was no documentation the BS logs for 05/05/22 to 06/30/22 were sent to the Endocrinologist for review.

Interview with a medication aide (MA) on 07/01/22 at 11:45am revealed:
-A low blood sugar for Resident #3 was below 80.
-Resident #3 liked to exercise and would not eat his meals.
-She could tell when Resident #3's BS was low because he would look "wobbly" on his feet.
-She would sit the resident down in a chair and check his BS.
-If it was low, she would give him 4 ounces (oz.) of orange juice and two peanut butter crackers.
-She had never had trouble with Resident #3 being unable to swallow when his sugar was low.
-But, if she was in doubt if the resident could safely swallow, she would call 911.
-She would not call the physician about low blood sugars unless there was an order to do so.
-She always informed the Resident Care Coordinator (RCC) as soon as possible when a resident BS was low and the treatment given to bring the BS up.
-She documented interventions to get the BS up on the back of the MAR.
-The RCC was responsible to notify the physician of low BS results.

Interview with a second MA on 07/01/22 at 12:10pm revealed:
-A low blood sugar for Resident #3 was below 80.
-Resident #3 drank a lot of water and frequently

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walked outside in the hot sun and his sugar dropped.
-She routinely checked Resident #3's BS at 6:30am.
-If the resident's BS was 70, she would get a breakfast tray for the resident.
-If the resident's BS was 60 or below, she immediately got the resident 4 oz. of orange juice with a couple packs of sugar mixed in the juice to drink and a couple peanut butter crackers to eat.
-Food and juice were kept conveniently in the nourishment room for the residents.
-She rechecked the resident's BS in 30 minutes.
-She informed the RCC about the resident's low BS and intervention to get the BS up.
-The RCC was responsible to notify the physician of low BS results.

Interview with the RCC on 07/01/22 at 8:55am revealed:
-They called Emergency Medical Services (EMS) for Resident #3 on 06/22/22 due to a low blood sugar.
-EMS gave Resident #3 glucose gel to get the BS up.
-Resident #3 did not have to go to the hospital.
-She called the resident's Endocrinologist due to the low BS which required EMS intervention, but they did not return her call.
-So instead they took Resident #3 to his primary care provider's (PCP) office on 06/29/22 for a diabetes check after the incident.
-The PCP's office downloaded the resident's glucometer results, but they did not make any changes to the insulin orders.
-Endocrinology did not usually want the PCP to make changes to blood sugar management interventions.

Review of Resident #3's EMS incident report

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dated 06/22/22 revealed:
-Staff reported to EMS altered mental state for Resident #3 and realized his BS was 33 and gave him orange juice with sugar packets.
-EMS arrived on scene to find resident seated in a recliner in the lobby of the facility, alert and oriented x 4.
-BS assessed at 50 and the resident was administered oral glucose.
-Resident #3 ate a peanut butter and jelly sandwich.
-BS was assessed again at 73, then 77.
-Resident had been known to not eat all of his lunch and refused transport to the hospital at this time.
-Resident #3 was advised that he would need possibly need to eat extra snacks today and was given another oral glucose.
-Next BS was 85 so EMS and the resident completed refusal documentation form.
-EMS informed resident that if he did not eat today and if his BS did not stay up and EMS was called out again today that he would need to be transported to the hospital and the resident agreed to the same.

Interview with the RCC on 07/01/22 at 12:20pm revealed:
-The facility did not have a written policy on interventions for resident incidents of low BS.
-The policy was just to intervene to treat the low BS with juice and food and call 911 if the resident was not responding to the treatment.
-She had faxed the endocrinology office Resident #3's BS logs and called them, but they did not respond.
-The endocrinology office's voice mail message instructed not to leave multiple messages or that could delay a response.
-She did not document her attempts to

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communicate the BS results to the Endocrinologist.
-The resident had a follow-up appointment scheduled with the Endocrinologist on 08/30/22.

Telephone interview with a Diabetes Education Specialist at Resident #3's endocrinology office on 07/01/22 at 11:10am revealed:
-Resident #3 had last been seen in their office on 04/20/22.
-The PA who had seen Resident #3 on 04/20/22 had asked for blood sugar logs to be sent to the office for review within 2 weeks to see if insulin adjustments were needed.
-They had received no communication from the facility since 04/20/22.
-The facility staff should have notified them of any blood sugar results below 70, so they could adjust the resident's insulin.
-Low blood sugar levels could cause confusion, falls, heart attack, and seizures.

Telephone interview with the Administrator on 07/01/22 at 2:30pm revealed the RCC was responsible for handling issues involving clinical concerns.

Telephone interview with Resident #3's PCP's certified medical assistant on 07/05/22 at 1:16pm revealed:
-Resident #3 was seen in their office on 06/29/22 for a diabetes check.
-They always went over Resident #3's medications when they saw him on these visits.

_____

The facility failed to provide 2 weeks' worth of blood sugar results for Resident #3 per Endocrinologist request during a visit on 04/20/22 to allow for review and insulin adjustment. The facility documented 24 blood sugar results less

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D 273	Continued From page 7 than 80 from 04/20/22 to 06/30/22 which ranged from 29-77, requiring EMS intervention on 06/22/22 for a blood sugar of 33. This failure was detrimental to the health, safety, and welfare of Resident #3 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/01/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 15, 2022.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (Resident #3) related to insulin. The findings are: Review of Resident #3's current FL2 dated 04/13/22 revealed:	D 358		

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D 358	Continued From page 8 -Diagnoses included hyperglycemia (an excess of glucose in the bloodstream, often associated with diabetes mellitus). -There was an order for Novolog (a rapid acting insulin used to lower blood glucose) Flexpen 100 unit/ml 7 units before breakfast give with sliding scale: 150-199=1 unit, 200-249=2 units, 250-299=3 units, 300-349=4 units, 350-399=5 units, 400 or greater= 6 units, hold if blood sugar (BS) is below 80. -There was an order for Novolog Flexpen 100 unit/ml 7 units before lunch give with sliding scale: 150-199=1 unit, 200-249=2 units, 250-299=3 units, 300-349=4 units, 350-399=5 units, 400 or greater= 6 units, hold if blood sugar is below 80. -There was an order for Novolog Flexpen 100 unit/ml 10 units before supper give with sliding scale: 150-199=1 unit, 200-249=2 units, 250-299=3 units, 300-349=4 units, 350-399=5 units, 400 or greater= 6 units, hold if blood sugar is below 80. Review of Resident #3's Endocrinology Physician's Assistant (PA) orders dated 04/20/22 revealed: -There was an order for Novolog Flexpen 100 unit/ml 5 units before breakfast, 5 units before lunch, and 8 units before supper, give with sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5 units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units, hold only if blood sugar is below 80. -Check blood sugar (BS) before meals and before bedtime and please bring your meter to all appointments. -Follow-up with Endocrinologist in 3 months. -Send blood glucose logs in 2 weeks for review/insulin adjustment.	D 358		

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D 358	Continued From page 9 Review of Resident #3's April 2022 Medication Administration Record (MAR) revealed: -There was an entry for Novolog 100 unit/ml 7 units before breakfast, 7 units before lunch, and 10 units before dinner hold if BS is below 80 scheduled for 6:30am, 11:30am, and 4:30pm. -There was an entry for Novolog 100 unit/ml inject per sliding scale: 150-199=1 unit, 200-249=2 units, 250-299=3 units, 300-349=4 units, 350-399=5 units, 400 or greater= 6 units scheduled at 6:30am, 11:30am, and 4:30pm. -There were no documented administrations and a handwritten note beside the entry to "See Attachment Sheet." -There was a handwritten entry for Novolog 100 unit/ml 5 units before breakfast and lunch and 8 units before supper along with sliding scale insulin scheduled at 6:30am, 11:30am, and 4:30pm. -There was a handwritten entry for Novolog 100 unit/ml per sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5 units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units scheduled for 6:30am, 11:30am, and 4:30pm. -There were no documented administrations and a handwritten note beside the entry to "See Attachment Sheet." Review of Resident #3's April 2022 insulin administration and BS logs dated 04/01/22 to 04/21/22 revealed: -There was a log for Novolog 100 unit/ml 7 units before breakfast, give with sliding scale: 150-199=1 unit, 200-249=2 units, 250-299=3 units, 300-349=4 units, 350-399=5 units, 400 or greater= 6 units scheduled for 6:30am. -There was a log for Novolog 100 unit/ml 7 units	D 358		

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before lunch, give with sliding scale: 150-199=1 unit, 200-249=2 units, 250-299=3 units, 300-349=4 units, 350-399=5 units, 400 or greater= 6 units scheduled for 11:30am.
-There was a log for Novolog 100 unit/ml 10 units before supper, give with sliding scale: 150-199=1 unit, 200-249=2 units, 250-299=3 units, 300-349=4 units, 350-399=5 units, 400 or greater= 6 units scheduled for 4:30pm.
-On 04/01/22 at 4:30pm, the BS was 110, 10 units required, 0 units were documented as administered.
-On 04/09/22 at 6:30am, the BS was 245, 9 units were required, 2 units were documented as administered.
-On 04/20/22 at 11:30am, the BS was 161, 8 units were required, 1 unit was documented as administered.
-On 04/20/22 at 4:30pm, the BS was 450, 16 units were required, 17 units were documented as administered.
-The BS range was 93-450.
-The Novolog was documented as administered incorrectly for 4 occurrences out of 44 opportunities.

Review of Resident #3's April 2022 insulin administration and BS log dated 04/22/22 to 04/30/22 revealed:
-There was a log for Novolog 100 unit/ml 5 units before breakfast give with sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5 units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units scheduled for 6:30am.
-There was a log for Novolog 100 unit/ml 5 units before lunch give with sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5

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units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units scheduled for 11:30am.
-There was a log for Novolog 100 unit/ml 8 units before supper give with sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5 units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units scheduled for 4:30pm.
-On 04/23/22 at 4:30pm, the BS was 90, 8 units were required, 0 units were documented as administered.
-On 04/24/22 at 6:30am, the BS was 95, 5 units were required, 0 units were documented as administered.
-On 04/24/22 at 4:30pm, the BS was 120, 8 units were required, 0 units were documented as administered.
-On 04/26/22 at 6:30am, the BS was 81, 5 units were required, 0 units were documented as administered.
-On 04/29/22 at 4:30pm, the BS was 131, 8 units were required, 0 units were documented as administered.
-The BS range was 41-356.
-The Novolog was documented as administered incorrectly for 5 occurrences out of 23 opportunities.

Review of Resident #3's May 2022 MAR revealed:
-There was a handwritten entry for Novolog 100 unit/ml 5 units before breakfast and lunch, and 8 units before supper scheduled at 6:30am, 11:30am, and 4:30pm.
-There were no documented administrations and a handwritten note beside the entry to "See Attachment Sheet."
-There was a handwritten entry for Novolog 100

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unit/ml per sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5 units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units scheduled for 6:30am, 11:30am, and 4:30pm.
-There were no documented administrations and a handwritten note beside the entry to "See Attachment Sheet."

Review of Resident #3's May 2022 insulin administration and BS log dated 05/01/22 to 05/31/22 revealed:
-There was a log for Novolog 100 unit/ml 5 units before breakfast give with sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5 units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units scheduled for 6:30am.
-There was a log for Novolog 100 unit/ml 5 units before lunch give with sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5 units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units scheduled for 11:30am.
-There was a log for Novolog 100 unit/ml 8 units before supper give with sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5 units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units scheduled for 4:30pm.
-On 05/02/22 at 6:30am, the BS was 101, 5 units were required, 0 units were documented as administered.
-On 05/03/22 at 6:30am, the BS was 181, 6 units were required, 0 units were documented as administered.

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D 358	Continued From page 13 -On 05/03/22 at 4:30pm, the BS was 117, 8 units were required, 0 units were documented as administered. -On 05/04/22 at 4:30pm, the BS was 105, 8 units were required, 0 units were documented as administered. -On 05/09/22 at 4:30pm, the BS was 90, 8 units were required, 0 units were documented as administered. -On 05/10/22 at 6:30am, the BS was 85, 5 units were required, 0 units were documented as administered. -On 05/11/22 at 6:30am, the BS was 148, 5 units were required, 0 units were documented as administered. -On 05/15/22 at 4:30pm, the BS was 221, 11 units were required, 10 units were documented as administered. -On 05/17/22 at 4:30pm, the BS was 225, 11 units were required, 10 units were documented as administered. -On 05/18/22 at 4:30pm, the BS was 261, 12 units were required, 0 units were documented as administered. -On 05/19/22 at 4:30pm, the BS was 351, 14 units were required, 13 units were documented as administered. -On 05/20/22 at 4:30pm, the BS was 119, 8 units were required, 0 units were documented as administered. -On 05/23/22 at 4:30pm, the BS was 291, 13 units were required, 11 units were documented as administered. -On 05/24/22 at 4:30pm, the BS was 196, 10 units were required, 9 units were documented as administered. -On 05/25/22 at 4:30pm, the BS was 277, 12 units were required, 11 units were documented as administered. -On 05/26/22 at 4:30pm, the BS was 310, 13	D 358		

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units were required, 12 units were documented as administered.
-On 05/27/22 at 4:30pm, the BS was 300, 13 units were required, 12 units were documented as administered.
-On 05/28/22 at 4:30pm, the BS was 286, 12 units were required, 11 units were documented as administered.
-On 05/29/22 at 4:30pm, the BS was 110, 8 units were required, 0 units were documented as administered.
-On 05/30/22 at 4:30pm, the BS was 188, 10 units were required, 9 units were documented as administered.
-On 05/31/22 at 4:30pm, the BS was 281, 12 units were required, 11 units were documented as administered.
-The BS range was 42-407.
-The Novolog was documented as administered incorrectly for 21 occurrences out of 62 opportunities.

Review of Resident #3's June 2022 MAR revealed:
-There was an entry for Novolog 100 unit/ml 5 units before breakfast scheduled at 6:30am with a handwritten note below the entry for the scheduled insulin to be administered along with sliding scale insulin (SSI) scheduled for 6:30am.
-There were no documented administrations and a handwritten note beside the entry to "See Attachment Sheet."
-There was an entry for Novolog 100 unit/ml 5 units before lunch with a handwritten note below the entry for the scheduled insulin to be administered along with SSI scheduled for 11:30am.
-There were no documented administrations and a handwritten note beside the entry to "See Attachment Sheet."

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D 358	Continued From page 15 -There was an entry for Novolog 100 unit/ml 8 units before supper with a handwritten note below the entry for the scheduled insulin to be administered along with SSI scheduled for 4:30pm. -There were no documented administrations and a handwritten note beside the entry to "See Attachment Sheet." Review of Resident #3's June 2022 insulin administration and BS log dated 06/01/22 to 06/30/22 revealed: -There was a log for Novolog 100 unit/ml 5 units before breakfast along with sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5 units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units scheduled for 6:30am. -There was a log for Novolog 100 unit/ml 5 units before lunch along with sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5 units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units scheduled for 11:30am. -There was a log for Novolog 100 unit/ml 8 units before supper along with sliding scale: less than 150= 0 units, 150-184=1 unit, 185-219=2 units, 220-254=3 units, 255-289=4 units, 290-324=5 units, 325-359=6 units, 360-394=7 units, 395-429=8 units, 430+= 9 units scheduled for 4:30pm. -On 06/12/22 at 6:30am, the BS was 120, 5 units were required, 0 units were documented as administered. -On 06/19/22 at 6:30am, the BS was 95, 5 units were required, 0 units were documented as administered. -On 06/24/22 at 6:30am, the BS was 93, 5 units	D 358		

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were required, 0 units were documented as administered.
-On 06/30/22 at 6:30am, the BS was 87, 5 units were required, 0 units were documented as administered.
-On 06/02/22 at 11:30am, the BS was 116, 5 units were required, 8 units were documented as administered.
-On 06/03/22 at 11:30am, the BS was 218, 7 units were required, 8 units were documented as administered.
-On 06/05/22 at 11:30am, the BS was 366, 12 units were required, 11 units were documented as administered.
-On 06/20/22 at 11:30am, the BS was 106, 5 units were required, 0 units were documented as administered.
-On 06/22/22 at 11:30am, the BS was 94, 5 units were required, 0 units were documented as administered.
-On 06/02/22 at 4:30pm, the BS was 305, 13 units were required, 12 units were documented as administered.
-On 06/03/22 at 4:30pm, the BS was 342, 14 units were required, 12 units were documented as administered.
-On 06/06/22 at 4:30pm, the BS was 430, 17 units were required, 14 units were documented as administered.
-On 06/07/22 at 4:30pm, the BS was 86, 8 units were required, 0 units were documented as administered.
-On 06/09/22 at 4:30pm, the BS was 205, 10 units were required, 11 units were documented as administered.
-On 06/13/22 at 4:30pm, the BS was 431, 17 units were required, 14 units were documented as administered.
-On 06/18/22 at 4:30pm, the BS was 111, 8 units were required, 0 units were documented as

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administered.
-On 06/19/22 at 4:30pm, the BS was 127, 8 units were required, 0 units were documented as administered.
-On 06/26/22 at 4:30pm, the BS was 88, 8 units were required, 0 units were documented as administered.
-On 06/29/22 at 4:30pm, the BS was 132, 8 units were required, 0 units were documented as administered.
-The BS range was 29-453.
-The Novolog was documented as administered incorrectly for 19 occurrences out of 75 opportunities.

Observation of Resident #3's medications on hand on 06/30/22 at 3:55pm revealed there was a Novolog Flexpen available with an open date of 06/23/22.

Interview with the Business Office Manager (BOM) and the Resident Care Coordinator (RCC) on 06/30/22 at 2:00pm revealed:
-The facility's policy was to administer medications as they were ordered.
-The medication aides (MAs) were all trained on how to administer scheduled insulin and insulin utilizing a sliding scale prior to being allowed to administer medications.
-They were not sure why the MAs had administered incorrect amounts of insulin.
-They thought some of the MAs may have failed to correctly document the scheduled amount of insulin they had administered.
-It appeared some of the MAs wrote 0 units when they did not administer the sliding scale insulin, but they may have correctly administered the scheduled insulin but did not document it.

Interview with the RCC on 07/01/22 at 8:55am

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revealed:
-She had faxed Resident #3's BS logs to the endocrinology office in June.
-She also called Resident #3's endocrinology office concerning the resident's low blood sugars in June.
-The endocrinology office did not return her calls.
-Resident #3 was seen by his primary care provider (PCP) on 06/29/22.
-The PCP downloaded the BS results from the resident's glucometer during the visit on 06/29/22.
-The PCP did not change Resident #3's insulin orders on the visit on 06/29/22.
-The Endocrinologist did not want other physician's to change orders related to BS management.
-The resident was to follow-up with the Endocrinologist on 08/30/22.

Telephone interview with a Diabetes Education Specialist at Resident #3's endocrinology office on 07/01/22 at 11:10am revealed:
-Resident #3 had last been seen in their office on 04/20/22.
-The facility staff should notify them of any blood sugar results below 70, so they could adjust the resident's insulin.
-They had received no communication from the facility since 04/20/22.
-They needed all of the resident's records (BS logs, MARs) to be able to adjust the resident's insulin orders.
-Low blood sugar levels could cause confusion, falls, heart attack, and seizure.

Interview with an MA on 07/01/22 at 11:45am revealed:
-All MAs were trained on insulin administration prior to be allowed to administer medications.
-According to Resident #3's scheduled and sliding

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D 358	Continued From page 19 scale insulin orders, if the blood sugar was between 81-149, she would administer the scheduled dose of insulin only. Telephone interview with the Administrator on 07/01/22 at 2:30pm revealed: -The facility policy was to administer medications as ordered. -The RCC was responsible for handling issues involving clinical concerns. Telephone interview with Resident #3's PCP's certified medical assistant (CMA) on 07/05/22 at 1:16pm revealed: -Resident #3 was seen in their office on 06/29/22 for a diabetes check. -They always went over Resident #3's BS logs and medications when they saw him on these visits. _____ The facility failed to administer insulin as ordered for Resident #3 resulting in unstable blood sugar results with one blood sugar as low as 29 (documented on 06/21/22 at 6:30am) and as high as 453 (documented on 06/18/22 at 6:30am). This failure was detrimental to the 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 06/30/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 15, 2022.	D 358		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp)	D 612		

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D 612	Continued From page 20 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to protect residents from infection during the global coronavirus (COVID-19) pandemic as related to the screening of residents. The findings are: Review of the CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes dated 02/02/22 revealed: -Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection. -Monitor residents at least daily for fever (temperature greater than or equal to 100	D 612		

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degrees F) and symptoms consistent with COVID-19.

Review of the Department of Health and Human Services (DHHS) COVID-19 Infection Prevention Guidelines for Long-Term Care Facilities dated 02/10/22 revealed:
-DHHS continues to recommend facilities, residents, families, and visitors adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure.
-Monitor residents daily for signs and symptoms of COVID-19.

Interview with the Resident Care Coordinator (RCC) on 06/30/22 at 8:50am revealed:
-The facility census was 40.
-There were no positive cases of COVID-19 currently in the facility.

Interview with one resident on 06/30/22 at 10:00am revealed:
-He had been told to inform staff if he was experiencing any symptoms of COVID-19.
-Staff checked resident temperatures only if they were experiencing symptoms of COVID-19.

Interview with the RCC on 06/30/22 at 2:00pm revealed:
-They had just come out of COVID-19 outbreak status.
-Residents were not being screened daily for symptoms of COVID-19.
-Staff would check a resident's temperature if a resident reported they felt feverish or were experiencing symptoms of COVID-19.
-She would perform a rapid COVID-19 test on any resident who had a fever or reported symptoms of COVID-19.
-If the rapid COVID-19 test was negative, she

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would retest the resident in 5 days.

Telephone interview with the local health department communicable disease Registered Nurse (RN) on 07/01/22 at 9:04am revealed:
-The facility had just come out of COVID-19 outbreak status.
-The facility did not have to continue checking temperatures on all residents every day.
-Temperatures should be checked if the residents were symptomatic or per the facility's policy.

Interview with a medication aide (MA) on 07/01/22 at 11:45am revealed:
-She did not check resident temperatures or ask them questions to screen them for symptoms of COVID-19 every day.
-She checked a resident's temperature if the resident told her they were experiencing symptoms of COVID-19 or if they did not feel well.
-She reported all resident fevers and symptoms of COVID-19 to the RCC, so the RCC could perform a rapid COVID-19 test.

Interview with a second MA on 07/01/22 at 12:10pm revealed:
-She only checked a resident's temperature if they told her they did not feel well.
-They did not check temperatures or ask screening questions for COVID-19 on all residents every day.

Interview with the RCC on 07/01/22 at 1:52pm revealed she had not discussed routine COVID-19 screening of resident with the local health department communicable disease RN.

Interview with the Administrator on 07/01/22 at 2:30pm revealed:

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D 612	Continued From page 23 -He was not aware residents were supposed to have their temperatures checked and be screened daily for symptoms of COVID-19. -The RCC was responsible for ensuring resident screening for COVID-19 according to the recommended guidance. On 06/30/22 at 2:00pm an initial request for the following information revealed: -Daily request for the facility's COVID-19 infection control policy was not provided during the survey. -Daily request for the facility's general infection control policy was not provided during the survey.	D 612		
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, and in compliance with relevant federal and state laws and rules and regulations related to health care and medication administration. The findings are: 1. Based on interviews and record review, the facility failed to send blood sugar (BS) log results for 1 of 2 sampled resident (Resident #3) with orders for blood sugar checks and insulin. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care	D912		

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D912	Continued From page 24 (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (Resident #3) related to insulin. [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		