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THE BRADFORD VILLAGE OF KERNERSVILLE - WES	602 PINEY GROVE ROAD KERNERSVILLE, NC 27284

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on October 6-8, 2021 and October 11-12, 2021 with an exit conference via telephone on October 12, 2021.	D 000		
D 201	10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)	D 201		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure the required staffing hours were met on third shift (11:00pm to 7:00am) based on a census of 49 for 5 of 6 sampled shifts from 08/25/21 to 10/06/21.

The findings are:

Observation on 10/06/21 between 10:00am and 11:40am during the initial tour revealed the facility did not have a sprinkler system

Review of staff timecards and facility census revealed staff shortages for 3 of 3 sampled days from 08/25/21 to 08/31/21 as follows:
-On 08/25/21 the census was 47 residents which required 16 aide hours; on third shift there was a total of 8 aide hours with a shortage of 8 aide hours.
-On 08/30/21 the census was 46 residents which required 16 aide hours; on third shift there was a total of 8 aide hours with a shortage of 8 aide hours.
-On 08/30/21 the census was 46 residents which required 16 aide hours; on third shift there was a total of 8 aide hours with a shortage of 8 aide hours.

Review of staff timecards and facility census

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revealed staff shortages for 2 of 3 sampled days from 10/05/21 to 10/06/21 as follows:
-On 10/05/21 the census was 49 residents which required 16 aide hours; on third shift there was a total of 8 aide hours with a shortage of 8 aide hours.
-On 10/06/21 the census was 49 residents which required 16 aide hours; on third shift there was a total of 8 aide hours with a shortage of 8 aide hours.

Interview with a resident on 10/08/21 at 1:20pm revealed:
-There were times when only one personal care aide (PCA) and one medication aide were on duty.
-That was mainly on the night shift.
-It took staff a longer time to respond to call bells when there was one aide providing care for over 40 residents; sometimes it took 45 minutes for staff to respond.

Interview with a third shift medication aide/Supervisor (MA/S) on 10/11/21 at 12:40pm revealed:
-There were 2 PCAs and the MA/S working the third shift in the past.
-There had been 2 staff who quit recently.
-She had worked with one PCA in the facility for the last couple of months.
-Occasionally, another PCA, came in around 4:30am to 5:00am to assist getting residents up for breakfast in order for the MA/S to check fingerstick blood sugars (FSBS) before 7:00am.

Interview with the Staffing and Transportation Coordinator on 10/11/21 at 3:00pm revealed:
-She occasionally assisted with personal care for residents.
-The facility had experienced staff turnover and

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had staff out for medical reasons placing the facility in a staffing shortage.
-She was told by the Executive Director (ED) there must be at minimum 2 staff working third shift.
-She made sure there was a MA/S and a PCA working third shift.
-There were residents quarantined for COVID-19 which required staff to apply personal protection equipment to provide care for them and a few residents that required 2 person assist with transfers which could make it difficult for 2 staff to care for 48 or 49 residents.

Interview with the ED on 10/11/21 at 12:00pm revealed:
-The facility had been staffing with 16 aide hours on third shift plus 8 hours for a medication aide/Supervisor until around August 2021.
-The facility had experienced staff turnover and staff shortages.
-The facility had been trying to add additional staff.
-She and the Staffing and Transportation Coordinator worked together to schedule staff for the facility.
-She was familiar with the staff chart used to determine staff requirements based on the facilities' daily census.
-The staffing chart clearly indicated 16 aide hours were required for the third shift for a census of 41 to 50 residents.
-She had a medication aide/Supervisor scheduled and worked 8 hours each third shift and a personal care aide (PCA) for a total of 16 hours.
-Occasionally she had an additional aide for 16 aide hours plus 8 Supervisor hours, but not many times recently.

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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, record reviews and interviews, the facility failed to ensure the provider was notified for 2 of 6 sampled residents (#1 and #3) related to low or elevated blood sugars with hypoglycemic episodes (#3), and not obtaining an anti-depressant medication following a provider consultation (#1). The findings are: 1. Review of Resident #3's current hospital FL2 dated 08/09/21 revealed: -Diagnoses included diabetes mellitus, and essential hypertension (high blood pressure). -Resident #3 was constantly disoriented. Review of Resident #3's Care Plan dated 05/31/21 revealed Resident #3 required limited assistance with activities of daily living including toileting, bathing, dressing and ambulation. a. Review of Resident #3's physician's orders revealed: -There was a physician's order dated 08/06/21 for Lantus insulin (a long acting insulin used to lower blood sugar levels) inject 15 units subcutaneously twice a day. -There was a physician's order dated 08/06/21 for Humalog insulin (a rapid acting insulin to lower	D 273		

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blood sugar levels) 7 units 3 times a day with meals, hold if blood sugar less than 100 or patient not eating.
-There was a physician's order dated 08/13/21 for Lantus insulin inject 20 units subcutaneously twice a day.
-There was a physician's order dated 08/27/21 for Humalog 9 units 3 times a day with meals, hold if blood sugar less than 100 or patient not eating.
-There was a physician's order dated 09/03/21 for Lantus insulin inject 20 units in the morning and 30 units at night.

Review of Resident #3's incident and accident reports revealed:
-On 08/31/21 at 5:30am, staff reported Resident #3 was acting completely out of her normal behavior.
-Resident #3 was refusing assistance with being changed and was being combative toward staff.
-Resident #3 then "threw herself to the floor".
-Resident #3 was taken by local emergency management services (EMS) to a local hospital emergency room (ER).

Review of Resident #3's hospital after visit summary dated 08/31/21 revealed:
-Resident #3's reason for the visit was a fall.
-Resident #3 was diagnosed with hypoglycemia, and a fall.
-There were information sheets for preventing falls and low blood sugar discharge instructions including most common causes of low blood sugar being taking too much insulin, skipping meals or not eating enough after eating meals.

Review of Resident #3's August 2021 electronic medication administration record (eMAR) revealed:
-Fingerstick blood sugar (FSBS) values recorded

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at 8:00am ranged from 50 (on 08/24/21) to 551.
-FSBS values recorded at 11:30am ranged from 68 to 584.
-FSBS values recorded at 4:30pm ranged from 122 to 489.
-FSBS values recorded at 8:00pm ranged from 151 to 503.
-The FSBS value on 08/30/21 at 4:30pm was 358 with 9 units of Humalog insulin was documented as administered, and at 8:00pm was 442.
-On 08/30/21 at 8:00pm, 20 units of Lantus insulin was documented as administered.

Review of Resident #3's hospital encounter documentation dated 09/07/21 at 8:24am revealed:
-Resident #3 presented to the ER via EMS complaining of hypoglycemia at the assisted living facility.
-Resident #3's FSBS was found to be in the 40's at the facility.
-The resident's FSBS was 42 on arrival to the ER.

Review of Resident #3's hospital encounter documentation dated 09/19/21 at 10:20am revealed:
-Resident #3 presented to the ER via EMS complaining of hypoglycemia at the facility.
-Resident #3's FSBS was found to be 41 in route to the hospital and glucose supplement (to raise blood sugar) was administered by EMS.
-The resident's FSBS was 141 on arrival to the ER.

Review of Resident #3's September 2021 eMAR revealed:
-FSBS values recorded at 8:00am ranged from 94 to 432.
-FSBS values recorded at 11:30am ranged from 74 to 580.

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-FSBS values recorded at 4:30pm ranged from 122 to 565.
-FSBS values recorded at 8:00pm ranged from 130 to 583.
-On 09/18/21 at 8:00pm, FSBS was documented as 316.
-On 09/18/21 at 4:30pm, FSBS was documented as 395 with documentation for 9 units Humalog as administered.
-On 09/18/21 at 8:00pm, 30 units of Lantus insulin was documented as administered.
-On 09/06/21 at 8:00pm, FSBS was documented as 424.
-On 09/06/21 at 4:30pm, FSBS was documented as 325 with no documentation for the amount of Humalog administered.
-On 09/06/21 at 8:00pm, Lantus insulin was documented for 30 units administered.

Telephone interview with a first shift medication aide (MA) on 10/12/21 at 11:02am revealed:
-She was working on 09/19/21 when Resident #3 was found at 10:00am on the floor in her room and appeared to be having a seizure.
-She checked and the resident's FSBS was documented for 149 at 6:30am and the resident received 9 units of Humalog insulin according to the eMAR.
-She did not recheck Resident #3's FSBS due to apparent seizure activity.
-The Resident Care Coordinator (RCC) completed the incident report and should have notified the primary care provider (PCP) and any responsible parties.
-She did not know what the resident's FSBS result was at the time of the incident.

Review of Resident #3's subsequent physician's orders revealed:
-There was a physician's order dated 09/03/21 for

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Lantus insulin inject 20 units in the morning and 30 units at night.
-There was a physician's order dated 09/24/21 for Humalog 10 units 3 times a day with meals, hold if blood sugar less than 100 or patient not eating.

Review of Resident #3's October 2021 eMAR from 10/01/21 to 10/06/21 revealed:
-FSBS values recorded at 8:00am ranged from 188 to 257.
-FSBS values recorded at 11:30am ranged from 157 to 559.
-FSBS values recorded at 4:30pm ranged from 289 to 413.
-FSBS values recorded at 8:00pm ranged from 211 to 375.
-On 10/05/21 at 4:30pm, FSBS was documented as 289 with no documentation for the amount of Humalog administered.
-On 10/05/21 at 8:00pm, FSBS was documented as 211.
-On 10/05/21 at 8:00pm, 30 units of Lantus insulin was documented as administered.

Review of the facility incident and accident report for Resident #3 dated 10/06/21 revealed:
-At 4:45am, Resident #3 was found on the floor of her bedroom.
-The resident responded to her name being called but started having seizure like activity.
-EMS was called and the resident was transported to the local ER.

Review of Resident #3's hospital encounter documentation dated 10/06/21 at 6:29am revealed:
-Resident #3 presented to the ER via EMS for possible seizure, and an unwitnessed fall.
-The resident was found to be hypoglycemic pre-hospital.

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-The resident's FSBS was 28 on arrival to the ER and treated for hypoglycemia.

Based on interviews and record review, it was determined Resident #3 was not interviewable.

Telephone interview with a third shift MA on 10/11/21 at 12:40pm revealed:
-Resident #3 had a history of seizures.
-Resident #3 seemed to be having seizures when she had observed her after falls or unresponsive.
-On 10/06/21 at 4:45am, she was checking on Resident #3 for morning incontinence care and awakening for breakfast.
-Resident #3 was on the floor in her room.
-The MA called her name and she responded, then started to have a seizure.
-She did not administer insulin or take the morning FSBS reading for Resident #3.
-She had not taken the resident's FSBS for the morning of 10/06/21, because the resident was showing "seizure-like shaking" in her hands and she was not comfortable trying to hold the resident tight enough to get a FSBS.
-She called EMS for the resident.
-She thought the RCC would be responsible to follow-up with the incident reports and medication changes.

Telephone interview with Resident #3's PCP on 10/12/21 at 2:18pm revealed:
-She had been notified that Resident #3 was sent out to the local ER on several occasions.
-She had last seen Resident #3 on 09/24/21 at the facility.
-The PCP was not notified that Resident #3 had been sent to the ER with episodes and diagnoses of hypoglycemia.
-She did not recall reviewing the discharge information from the resident's ER encounters

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that had the hypoglycemia diagnosis.
-She did not have access to the on-line discharge reports for Resident #3.
-She was adjusting insulins upward to help control high FSBS values based on reviews of the eMARs.

2. Review of Resident #1's current FL2 dated 09/05/21 revealed diagnoses included diabetes mellitus type II, hypertension, and glioblastoma.

Review of Resident #1's progress notes and electronic medication administration records (eMARs) revealed:
-The resident was out of the facility at the hospital for a psychiatric evaluation from 09/10/21 and did not return until 09/11/21.
-There was no hospital discharge paperwork, orders or documentation related to a psychiatric evaluation in the resident's record.

At the request of the surveyor, on 10/08/21, the Administrator obtained a psychiatry evaluation consult report dated 09/10/21.

Review of Resident #1's psychiatry consult evaluation report obtained by the Administrator on 10/08/21 revealed:
-Resident #1 was at the emergency department on 09/10/21 with complaints of psychiatric disturbance consisting of suicidal ideations.
-The evaluator documented the resident had suicidal thoughts since his glioblastoma (an aggressive type of brain cancer) surgery in May 2021.
-Resident #1's final diagnosis was severe depression.
-The psychiatry consult included an order for Remeron (used to treat depression) 7.5mg nightly.

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-Resident #1 was transferred back to the facility at 9:00am on 09/11/21.

Review of Resident #1's hospital discharge summary report date 09/10/21 revealed:
-The resident was "profoundly" depressed and expressed suicidal ideation.
-The resident admitted to the evaluator that he frequently contemplated ways to end his life.
-Remeron 7.5mg at bedtime was ordered to assist with the depression.
-There was documentation the hospital staff called the facility and spoke with the Staffing/Transportation Coordinator (STC) and explained the resident would be returning to the facility, and would need continued psychiatry care.

Review of Resident #1's September 2021 electronic medication administration record (eMAR) revealed there was no entry for Remeron 7.5mg on the eMAR.

Interview with Resident #1's family member on 10/11/21 at 3:08pm revealed:
-When Resident #1 returned to the facility from the hospital on 09/11/21 he was brought to the facility by hospital transportation because of his wheelchair.
-The paperwork accompanied the resident back to the facility.
-On 09/13/21, she talked with the facility's Resident Care Coordinator (RCC) and asked about Resident #1's medication that was prescribed by the psychiatrist on 09/10/21 for depression (Remeron).
-The RCC said she could not find any discharge paperwork related to the psychiatry consult on 09/10/21.
-She even showed the RCC that the medication

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was listed on Resident #1's Primary Care Provider (PCP) medication list and that Resident #1 should be administered the medication.
-The RCC told her that the facility did not have the paperwork from the psychiatric evaluation on 09/10/21.
-She suggested the facility obtain the paperwork from the psychiatric evaluation on 09/10/21 that included the medication for depression.
-On 09/27/21, she asked another MA about the Remeron.
-The MA checked the facility's eMAR and identified Resident #1 was still not being administered the medication.
-On 09/30/21, she asked the MA to show her Resident #1's medications.
-She observed Resident #1 was still not administered the Remeron, and the medication was not in the facility.
-She asked the MA about the medication, but the MA did not know why the medication was not in the facility.

Interview with the STC on 10/11/21 at 1:10pm revealed:
-When Resident #1 returned to the facility on 10/11/21, no paperwork accompanied the resident.
-She was not responsible for obtaining paperwork for residents that returned from the hospital.
-If a resident returned from the hospital without discharge paperwork, the MA on duty or the RCC was responsible for contacting the discharging hospital to request the paperwork.

Interview with a MA on 10/11/21 at 5:00pm revealed:
-She was unable to recall if she worked on 09/11/21 when Resident #1 returned to the facility from his hospital psychiatry consult.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRADFORD VILLAGE OF KERNERSVILLE - WES	602 PINEY GROVE ROAD KERNERSVILLE, NC 27284

(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
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-If the resident did not come back to the facility with discharge paperwork, then the MA on duty should have contacted the hospital to obtain the paperwork.
-She recalled the resident's family member asking her about Resident #1's medication on 09/30/21.
-She identified from the eMAR that Remeron was not on the eMAR.
-She checked the resident's medications and Remeron was not available for administration.
-She did not contact the hospital but let the RCC know.
-The resident had not returned back to the facility since 09/30/21.

Interview with the Executive Director (ED) on 10/08/21 at 5:40pm revealed:
-If a resident returned from the hospital without discharge paperwork, the MA or the RCC should contact the hospital to obtain the paperwork.
-She did not know Resident #1's paperwork was not in the facility until requested by the surveyor on 10/08/21.

Based on record reviews and interviews, the facility did not obtain Resident #1's psychiatric evaluation consult report dated 09/10/21, even after three requests were made by the resident's family member. The psychiatric evaluation included instructions to administer Remeron 7.5mg at bedtime to help with depression.

Attempted telephone interviews with the RCC on 10/08/21 at 5:33pm and 10/11/21 at 10:17am were unsuccessful.

Attempted telephone interview with Resident #1's psychiatrist on 10/12/21 at 9:50am was unsuccessful.

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D 273	Continued From page 14 The facility failed to ensure PCP notification for 2 of 6 sampled residents including a resident with ordered FSBS parameters and FSBS rechecks resulting in hospitalizations for hypoglycemic episodes (#3); obtain discharge paperwork from a psychiatric evaluation that included instructions to administer a medication to help with depression and suicidal ideations for a resident with a history of depression (#1). This failure was detrimental to health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/08/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 26, 2021.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, record reviews, and	D 276		

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interviews, the facility failed to ensure physician's orders were implemented for 4 of 5 sampled residents (#2, #3, #4, and #9) with an order for fingerstick blood sugars (FSBS) four times daily (#4), an order to recheck FSBS and notify the physician (#9), an order to check blood pressure and heart rate daily and not rechecking FSBS when blood sugars were greater than 450 (#3), and an order for thrombo-embolus deterrent (TED) hose (#2).

The findings are:

1. Review of Resident #9's current FL2 dated 07/25/21 revealed diagnoses included diabetes mellitus.

Review of Resident #9's physician's orders revealed there was an order dated 07/30/21 for Novolog (fast-acting insulin used to control diabetes) 5 units subcutaneously four times daily as needed for FSBS greater than 450. Recheck in one hour if FSBS not lower notify primary care provider (PCP).

Review of Resident #9's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog 5 units subcutaneously four times daily as needed for FSBS greater than 450. Recheck in one hour if FSBS not lower notify provider.
-There were 6 FSBS results documented on the September 2021 eMAR greater than 450, and required a recheck and/or notify the PCP if not lowered as follows:
-On 09/04/21 at 11:30am FSBS was 514.
-On 09/16/21 at 4:30pm FSBS was 469.
-On 09/17/21 at 11:30am FSBS was 466.
-On 09/19/21 at 8:00pm FSBS was 470.

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-On 09/20/21 at 4:30pm FSBS was 455.
-On 09/22/21 at 4:30pm FSBS was 514.
-There was no documentation the FSBS were rechecked or PCP was notified as ordered.

Interview with Resident #9 on 10/11/21 at 1:15pm revealed;
-He had been a diabetic for years and was considered a "brittle diabetic."
-The MA checked his FSBS four times daily and administered insulin 4 maybe 5 times daily, but he was not sure.
-He usually asked the MA what his FSBS was, but his memory did not retain the FSBS very long.
-He knew that some of his FSBS were in the high, in the 400 and 500's but was unable to recall the last time his FSBS was high.
-There had been no time when the MA rechecked his FSBS within one hour after the initial FSBS was checked.
-He did not know he was ordered additional insulin when FSBS were greater than 450.

Telephone interview with a medication aide (MA) on 10/08/21 at 1:31pm revealed:
-She checked the resident's FSBS and when she finished she documented the FSBS on the eMAR.
-If there was documentation on the eMAR that she obtained Resident #9's FSBS on 09/16/21, and it was greater than 450 that was true.
-She was unable to recall if she rechecked the resident's FSBS or notified the resident's PCP.
-If she had rechecked the FSBS there should be documentation in the comment section of the eMAR.

Telephone interview with a second shift MA who documented five (4:30pm and 8:00pm) of Resident #9's FSBS on 10/07/21 at 5:19pm revealed:

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D 276	Continued From page 17 -When she worked second shift she checked Resident #9's FSBS two times at 4:30pm and 8:00pm. -She was unable to recall if she rechecked the FSBS when it was greater than 450 as ordered. -If there was no documentation of FSBS recheck on the eMAR, then she could not say that she rechecked the FSBS or the reason why she did not recheck the FSBS. -If for some reason the resident refused to let her recheck the FSBS or it was missed, the PCP should have been notified. -If there was no section to write a recheck on the eMAR she could document the recheck in the notes section of the eMAR. -She could not remember if she had notified the resident's PCP about the FSBS not being rechecked. Interview with Resident #9's PCP on 10/07/21 at 11:02am revealed: -Resident #9's FSBS were "all over the place." -His FSBS sometimes were high and she ordered SSI and a recheck within one hour. -If after one hour the FSBS was still greater than 450 she wanted to be notified. -If the staff were unable to recheck the FSBS they should still let her know. 2. Review of Resident #4's current FL2 dated 09/03/21 revealed: -Diagnoses included diabetes mellitus type II. -There was an order for Novolog (fast-acting insulin to control diabetes) 3 units subcutaneously four times daily as needed for fingerstick blood sugars (FSBS) greater than 450. Review of Resident #4's September 2021 electronic medication administration record (eMAR) revealed:	D 276		

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D 276	Continued From page 18 -There was an entry for Novolog 3 units subcutaneously four times daily as needed for FSBS greater than 450, with "PRN" documented under the hour. -There were no documented FSBS results on the September eMAR for Novolog 3 units obtained four times daily. -There was opportunity to obtain the resident's FSBS 120 times with possible insulin administration from 09/01/21 through 09/30/21. -There were 90 documented FSBS on the September 2021 eMAR from 09/01/21 through 09/30/21. -Without obtaining the resident's FSBS it could not be determined if 30 opportunities for FSBS were within range for an additional 3 units of Novolog as ordered. -In September 2021 the resident's documented FSBS on the eMAR ranged between 74 and 303. Based on observation, record review and attempted interview on 10/06/21 at 12:40pm it was determined that Resident #4 was not interviewable. Telephone interview with a second shift medication aide (MA) on 10/07/21 at 5:19pm revealed: -She checked Resident #4's FSBS once during her shift at 4:30pm. -She did not recall administering additional insulin for FSBS greater than 450. -She thought the order on the eMAR was PRN and the FSBS did not need to be checked every day. Interview with a second shift MA on 10/08/21 5:13pm revealed: -She did not know who entered the order for FSBS four times daily on the eMAR.	D 276		

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-She believed that she did not obtain the resident's FSBS a fourth time because "PRN" was documented on the eMAR.
-She was sure that she did not administer additional insulin for FSBS greater than 450.

Telephone interview with facility's contracted pharmacy on 10/08/21 at 1:23pm revealed:
-The pharmacy entered the order for Novolog 3 units as needed for FSBS greater than 450.
-The pharmacy did not enter a time because the order stated, "as needed, which was PRN."
-She had not checked with the PCP to ensure the order for FSBS four times daily should be scheduled.
-The pharmacy entered the facility's orders into the eMAR system, the facility had to review and approve the order before the they could document the order on the eMAR.
-If there was a concern the facility should contacted the resident's PCP or the pharmacy.

Interview with the Resident Care Coordinator (RCC) on 10/08/21 at 3:42pm revealed:
-She was not aware the MAs were not obtaining Resident #4's FSBS four times daily as ordered.
-The third shift MA and her audited the eMARs weekly to observe holes in the eMAR.
-She did not realize the order for FSBS four times daily give 3 units of Novolog for FSBS greater than 450 in the evening was missed.
-The MAs administering the medications should have identified the error on the eMAR and let her know.
-If the MAs were not sure if they should obtain the FSBS four times daily they should asked her or the PCP.

Interview with Resident #4's primary care provider (PCP) on 10/07/21 at 11:02am revealed:

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D 276	Continued From page 20 -She expected Resident #4's FSBS to be checked four times daily and insulin administered as ordered. -If staff did not checked the FSBS how would they know if the resident's blood was within range for administration insulin. -If staff did not understand the order; then they should have asked her, she was in the facility at least once weekly or staff could have called her. 3. Review of Resident #3's current hospital FL2 dated 08/09/21 revealed: -Diagnoses included diabetes mellitus, and essential hypertension (high blood pressure). -Resident #3 was constantly disoriented on the FL2. a. Review of Resident #3's physician's orders dated 08/05/21 and 09/03/21 revealed: -There were orders to check fingerstick blood sugar (FSBS) 4 times a day. -There were orders for Humalog (a rapid acting insulin) 100 units/milliliter Kwikpen (a dial-up insulin administration system) inject 3 units subcutaneously five times daily as needed for FSBS greater than 450. Recheck in one hour if FSBS not lower notify provider. Review of Resident #3's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog 3 units subcutaneously four times daily as needed for FSBS greater than 450. Recheck in one hour if FSBS not lower notify provider. -There were 6 FSBS documented on the eMAR that were greater than 450 and required recheck and/or notify the Primary Care Provider (PCP) as follows:	D 276		

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D 276	Continued From page 21 -On 08/13/21 at 11:30am, FSBS was 468 and there was no documentation the FSBS was rechecked or the PCP was notified. -On 08/14/21 at 6:30am, FSBS was 551 and there was no documentation the FSBS was rechecked or the PCP was notified. -On 08/16/21 at 6:30am, FSBS was 473 and at 4:30pm FSBS was 489 with no documentation the FSBSs were rechecked or the PCP was notified either time. -On 08/20/21 at 6:30am, FSBS was 473 and there was no documentation the FSBS was rechecked or the PCP was notified. -On 08/26/21 at 2:00pm, FSBS was 461 and there was no documentation the FSBS was rechecked or the PCP was notified. Review of Resident #3's September 2021 eMAR revealed: -There was an entry for Humalog 3 units subcutaneously four times daily as needed for FSBS greater than 450. Recheck in one hour if FSBS not lower notify provider. -There were 13 FSBS results documented on the eMAR that were greater than 450 and required recheck and/or notify the PCP with examples as follows: -On 09/05/21 at 11:30am, FSBS value was 503 and there was no documentation the FSBS was rechecked or the PCP was notified. -On 09/08/21 at 11:30am, FSBS value was 558 on the eMAR and resident's glucometer history and there was no documentation the FSBS was rechecked or the PCP was notified. -On 09/08/21 at 4:30pm, FSBS value was 505 on the eMAR and resident's glucometer history and there was no documentation the FSBS was rechecked or the PCP was notified. -On 09/13/21 at 11:30am, FSBS value was 550 on the eMAR and resident's glucometer history	D 276		

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and there was no documentation the FSBS was rechecked or the PCP was notified.
-On 09/22/21 at 11:30am, FSBS value was 580 on the eMAR and resident's glucometer history and there was no documentation the FSBS was rechecked or the PCP was notified.

Review of Resident #3's October 2021 eMAR revealed:
-There was an entry for Humalog 3 units subcutaneously four times daily as needed for FSBS greater than 450. Recheck in one hour if FSBS not lower notify provider.
-There was 1 FSBS reading documented on the eMAR that was greater than 450 and required recheck and/or notify the PCP.
-On 10/03/21 at 11:30am, FSBS value was 559 and there was no documentation the FSBS was rechecked or the PCP was notified.

Based on interviews and record review, it was determined Resident #3 was not interviewable.

Interview with Resident #3's PCP on 10/07/21 at 11:02am revealed:
-If a resident's FSBS readings were high, she ordered SSI and a recheck within one hour.
-If after one hour the FSBS was still greater than 450, she wanted to be notified.
-If the staff were unable to recheck the FSBS they should still let her know.

Telephone interview with a second shift medication aide (MA) on 10/07/21 at 5:19pm revealed:
-When she worked second shift she checked Resident #3's FSBS two times at 4:30pm and 8:00pm.
-She was unable to recall if she rechecked the FSBS greater than 450 as ordered.

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D 276	Continued From page 23 -If there was no documentation of a FSBS recheck on the eMAR, she could not say that she rechecked the FSBS or the reason why she did not recheck the FSBS. -If for some reason the resident refused to let her recheck the FSBS or it was missed, the PCP should have been notified. -If there was no section to write a recheck on the eMAR she could document the recheck in the notes section of the eMAR. -She could not remember if she had notified the resident's PCP about the FSBS not being rechecked or above 450. Telephone interview with another second shift MA on 10/08/21 at 1:31pm revealed: -She checked the resident's FSBS and when she finished the medication pass she documented the FSBS on the eMAR. -Sometimes she documented on the eMARs at the time she obtained the FSBS reading. -If there was documentation on the eMAR that she obtained a resident's FSBS reading, and it was greater than 450 that was true. -She was unable to recall if she rechecked the resident's FSBS or notified the resident's PCP. -If she had rechecked the FSBS there should be documentation in the comment section of the eMAR. Telephone interview with Resident #3's PCP on 10/12/21 at 2:18pm revealed: -Resident #3 had some high FSBS. -She did not know there were several times when her FSBS was over 450 and the facility did not recheck or let her know if the FSBS remained above 450. b. Review of Resident #3's physician's order dated 08/05/21 revealed an order to check blood	D 276		

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D 276	Continued From page 24 pressure (BP) 3 times a week, on Monday, Wednesday, and Friday. Review of Resident #3's physician order dated 08/27/21 revealed an order to increase the resident's medication for high BP and to check BP and heart rate daily and record on the electronic medication administration record (eMAR). Review of Resident #3's August 2021, September 2021 and October 2021 eMAR revealed: -There was an entry for BP check 3 times weekly, scheduled for each Monday, Wednesday, and Friday. -There was no entry to check BP and heart rate daily as ordered on 08/27/21 on the eMARs. -There were documented BP checks 3 times weekly for August 2021 with the range of 115/70 to 193/99. (The American Heart Association considers normal blood pressure range to be less than 120/80). -There were documented BP checks 3 times weekly for September 2021 with the range of 140/70 to 195/94. -There was a documented BP reading on 10/01/21 for October 2021 with a result of 166/70. -There was no documentation for daily BPs or heart rates on the resident's eMARs. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 10/11/21 at 10:20am revealed: -The pharmacy was responsible to enter physician orders on the eMAR. -The pharmacy received Resident #3's order dated 08/27/21 to increase the residents' BP medication and check BP and heart rate daily and record on the eMAR. -The pharmacy staff was responsible for order	D 276		

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entries on the eMAR and failed to include the BP checks that changed from 3 times a week to BP checks daily including heart rate checks daily.
-The facility was responsible to verify orders entered into the eMAR system and notify the pharmacy if the orders were incorrect or incomplete.

Interview with the Executive Director (ED) on 10/08/21 at 4:45pm revealed:
-She did not know Resident #3's BP and heart rate was to be taken daily until today (10/08/21).
-The Resident Care Coordinator (RCC) or the ED was responsible to ensure provider's orders were listed on the eMAR correctly.
-The RCC overlooked the part of Resident #3's order to change BP checks to daily and check heart rate when the BP medication was changed.
-There was no documentation the resident's PCP was notified regarding BP and heart rate not taken daily from 08/27/21 to 10/08/21 as ordered.

Attempted telephone interview with Resident #3's PCP on 10/12/21 at 11:54am was unsuccessful.

4. Review of Resident #2's current FL2 dated 07/21/21 revealed:
-Diagnoses included Parkinson's disease, hypertension, chronic pain and anxiety disorder.
-There was an order for bumetanide 1mg tablet once daily on Tuesdays, Thursdays and Saturdays (a medication used to treat fluid retention/edema or high blood pressure).

Review of Resident #2's physician's orders dated 08/06/21 revealed there was an order for medium-size knee-high TED hose (compression stockings used to treat swelling in the legs) to be applied to both legs every morning and removed every night at bedtime.

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D 276	Continued From page 26 Observation of Resident #2 on 10/08/21 at 1:25pm revealed: -There was an equal amount of swelling noted to both of her feet and ankles. -There was no redness, open skin or weeping of fluid to her legs. -She was not wearing TED hose. Interview with a personal care aide (PCA) on 10/08/21 at 10:25am revealed: -She had never seen TED hose in Resident #2's room or applied TED hose to Resident #2's legs. -She had observed swelling to Resident #2's feet daily when providing care to her. Interview with the Resident Care Coordinator (RCC) on 10/08/21 at 11:50 revealed: -The physician was supposed to fax new prescription orders to the pharmacy, and if there was a new order listed on the progress note the facility would fax that to the pharmacy. -The person responsible for reviewing the progress notes for new orders would either be herself or a medication aide (MA). -If there was a discrepancy with orders, either the pharmacy would clarify the order, or the facility would, depending on who found the discrepancy. -She did not know why the order for TED hose had been missed. Interview with a representative from the contracted pharmacy on 10/08/21 at 10:10am revealed: -They never received an order for TED hose for Resident #2. -If the doctor wrote an order for TED hose, the order should have been faxed to the pharmacy for dispensing.	D 276		

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D 276	Continued From page 27 Interview with Resident #2 on 10/08/21 at 1:20pm revealed: -Since admission to the facility, she had never had TED hose. -She remembered discussing TED hose with the physician but TED hose were never given to her. -She wanted the TED hose for the swelling in her feet and ankles. Interview with the Executive Director (ED) on 10/08/21 at 4:15pm revealed: -Resident progress notes with new primary care provider's (PCP) orders on them were faxed to the pharmacy by the PCP. -The RCC should also review notes from PCP visits for any new orders. -She did not know why the TED hose were not ordered. Attempted interview with Resident #2's primary care provider on 10/12/21 at 11:54am was not successful. _____ The facility failed to ensure implementation of physician's orders for 4 of 5 sampled residents (#2, #3, #4, and #9) with an order for fingerstick blood sugars (FSBS) four times daily (#4) an order to recheck FSBS if elevated, without rechecking the FSBS the placed the resident at risk for uncontrolled blood sugars that could possibly lead to deterioration of organs and loss of limbs (#9), an order to check blood pressure and heart rate daily placing the resident at risk for inappropriate blood pressure control and recheck elevated blood sugars placing the resident at danger for deterioration of organs (#3), and an order for thrombo-embolus deterrent (TED) hose for a resident receiving medication for fluid retention (#2).. The facility's failure was detrimental to health and safety of the residents	D 276		

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D 276	Continued From page 28 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/25/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 26, 2021.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure physician notification for clarification for 1 of 5 sampled residents (#2) with an order for an analgesic. The findings are: Review of Resident #2's current FL2 dated 07/21/21 revealed:	D 344		

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-Diagnoses included Parkinson's disease and chronic pain.
-There were two "as needed" (PRN) acetaminophen (Tylenol) orders: one for 325mg take two tablets once daily as needed, and one for 325mg take three tablets twice daily as needed for mild pain.

Review of Resident #2's subsequent physician's orders dated 08/06/21 revealed:
-The PRN Tylenol orders had been discontinued.
-There was an order for Tylenol 500mg, take 1 tablet twice daily with a start date of 07/30/21.
-There was a hand-written note to add Tylenol 500mg 1 tablet every 12 hours as needed for pain dated 08/06/21.

Review of Resident #2's progress note signed by Resident #2's primary care provider (PCP) dated 08/06/21 revealed there was an order to add Tylenol Extra Strength (ES) 1 tablet every 12 hours as needed for pain, keep scheduled dose as is.

Review of Resident #2's electronically faxed medication order dated 08/06/21 revealed an order for Tylenol ES 500mg tablets, take 1 tablet every twelve hours as needed for pain not to exceed 3 gm/24 hours.

Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Tylenol ES 500mg tablet, take 1 tablet twice daily scheduled for 6:00am and 5:00pm, which started on 07/30/21.
-Tylenol 500mg was documented as administered twice daily as ordered from 08/01/21 through 08/31/21.
-There was an entry for Tylenol 500mg tablet,

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take 1 tablet every 12 hours as needed for pain.
-The PRN Tylenol 500mg was documented as administered 12 times from 08/09/21 and 08/31/21.

Review of Resident #2's September 2021 eMAR revealed:
-There was an entry for Tylenol 500mg tablet take 1 tablet twice daily scheduled for 6:00am and 5:00pm with a discontinue date of 09/24/21.
-Tylenol 500mg was documented as administered twice daily as ordered from 09/01/21 though 09/24/21.
-There was an entry for Tylenol 500mg tablet, take 1 tablet every 12 hours as needed for pain.
-The PRN Tylenol 500mg was documented as administered 11 times from 09/01/21 though 09/30/21.

Review of Resident #2's October 2021 eMAR revealed:
-There was an entry for Tylenol 500mg tablet, take 1 tablet every 12 hours as needed for pain.
-There was no entry for Tylenol ES 500mg twice daily.

Observation of Resident #2's medications on hand on 10/07/21 at 2:50pm revealed:
-There were two medication cards for Tylenol ES 500mg tablets to use every 12 hours as needed for pain.
-One medication card was full with 30 tablets, dispensed on 09/23/21 and one medication card had 12 of 30 tablets remaining dispensed on 09/23/21.
-There was no Tylenol ES 500mg tablets available with instructions to administer twice daily.

Review of refill requests from the facility to the

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pharmacy dated 09/23/21 revealed:
-The facility faxed the pharmacy on 09/23/21 at 4:10pm, a refill request for Resident #2's Tylenol 500mg tablet.
-There was a text box on the response from the pharmacy on 09/24/21 at 9:00am, documenting the scheduled Tylenol had been discontinued and the resident was now only on PRN Tylenol.
-There was a handwritten note from the facility asking the pharmacy to send the discontinue order.
-There was a response from the pharmacy faxed back to the facility with the order for scheduled Tylenol dated 08/06/21 with a text box documenting the order had been changed from scheduled to PRN.

Telephone interview with a representative from the contracted pharmacy on 10/07/21 at 2:40pm revealed:
-The pharmacy received an electronic prescription from Resident #2's PCP on 08/06/21 for PRN Tylenol to take every 12 hours.
-The pharmacy had not received a copy of the PCP's progress note dated 08/06/21 documenting to keep the scheduled Tylenol order "as is."
-The pharmacy had added the text box to the electronic prescription that was faxed back to the facility stating the scheduled Tylenol order had been discontinued.
-They had not received an order to discontinue the scheduled Tylenol.

Interview with the Resident Care Coordinator (RCC) on 10/08/21 at 11:50am revealed:
-The PCP faxed any new medication orders to the pharmacy and if there was a new order listed on the PCP's progress note, the facility was supposed to fax the order to the pharmacy.

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-She or the MAs were responsible for reviewing PCP progress notes for new orders.
-If there was a discrepancy with orders either the facility or the pharmacy would clarify the order with the PCP, whoever noticed the discrepancy first.
-She did not know why the Tylenol order had not been clarified to determine whether or not the scheduled Tylenol order should have been discontinued.

Interview with Resident #2 on 10/08/21 at 1:20pm revealed:
-She was aware she was taking scheduled Tylenol for pain, and that she had additional Tylenol ordered to be available to her if needed.
-She had not noticed an increase in her pain since 09/24/21 when the scheduled Tylenol was discontinued.
-Her pain was always present and she had not noticed any change in the last couple of weeks.
-She thought she was still getting her Tylenol on a regular schedule because she looked for a white pill.

Interview with the Executive Director on 10/08/21 at 4:40pm revealed it was the RCC's responsibility to review PCP progress notes and fax any new orders to the pharmacy.

Telephone interview with a representative from the contracted pharmacy on 10/11/21 at 10:15am revealed:
-The pharmacy received a copy of the signed physician's order sheet dated 08/06/21.
-The pharmacy had discontinued the scheduled Tylenol order on 08/06/21, so they thought the facility must have done an override until they ran out of Tylenol and sent the refill request to them on 09/23/21.

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D 344	Continued From page 33 -Nobody from the facility had called the pharmacy to clarify the Tylenol order. Attempted telephone interview with Resident #2's PCP on 10/12/21 at 12:00pm was unsuccessful.	D 344		
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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a physician for 2 of 6 sampled residents (Resident #5 and #9) related to insulin. The findings are: 1. Review of Resident #5's current FL2 dated 05/31/21 revealed: -Diagnoses included type 2 diabetes mellitus and long-term use of insulin. -There was a physician's order for Humalog (a fast-acting insulin used to lower elevated blood sugar levels) sliding scale insulin (SSI) before meals. Review of signed physician's orders dated 06/09/21 revealed Humalog SSI order as follows:	D 358		

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D 358	Continued From page 34 Inject sliding scale before meals: 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, 401-450= 10 units, 451-500= 12 units, 501-999= 14 units; Schedule daily at 6:30am, 11;30am, and 4:30pm. Review of Resident #5's September electronic medication administration record (MAR) from 09/05/21 to 09/30/21 revealed: -There was no documentation showing how many units of sliding scale insulin (SSI) were administered based on FSBS readings; unable to determine if SSI was administered correctly. -There was documentation the FSBS documented on the eMAR did not match the FSBS recorded in the glucometer history for 4 of 78 opportunities: -On 09/06/21 at 4:30pm, FSBS documented on the eMAR was 231, FSBS recorded in the glucometer history was 261. -On 09/09/21 at 4:30pm, FSBS documented on the eMAR was 124, FSBS recorded in the glucometer history was 224. -On 09/20/21 at 4:30pm, FSBS documented on the eMAR was 109, FSBS recorded in the glucometer history was 209. -On 09/27/21 at 4:30pm, FSBS documented on the eMAR was 138, FSBS recorded in the glucometer history was 238. Interview with the Executive Director (ED) on 10/06/21 at 1:12pm revealed she had spoken with the contracted pharmacy earlier that morning when she was asked to provide documentation of how many units of SSI were administered as that information was missing from the MAR, they were unable to provide that documentation. Interview with a pharmacist from the contracted pharmacy on 10/07/21 at 9:10am revealed:	D 358		

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D 358	Continued From page 35 -There was no space available on the eMAR to document units of SSI administered. -The pharmacy had submitted a project request to have that space added on the eMAR which went into effect that day, on 10/07/21. -When the medication aide (MA) entered the FSBS reading from 10/07/21 going forward, the eMAR would prompt how many units of SSI to administer to the resident and provide a space for the MA to document how many units they administered. -The facility should have been keeping records of how many units of SSI they were administering elsewhere since there was not a designated place on the eMAR to documented units of SSI administered until today, 10/07/21. Interview with Resident #5 on 10/07/21 at 12:35pm revealed: -Staff checked his blood sugar three times per day and always told him what his FSBS reading was. -Staff would administer insulin to him if his FSBS reading was high, but he did not know what his blood sugar level needed to be in order for him to receive insulin. Interview with an MA on 10/07/21 at 3:00pm revealed: -There was a space on the eMAR to document units of SSI administered, and that option had been there since Resident #5 was admitted to the facility. -She demonstrated on the eMAR where to add a free-text note to indicate units of SSI administered. -She did not know if the other MAs knew about or were documenting units of SSI administered in the free text option.	D 358		

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D 358	Continued From page 36 Review of Resident #5's August, September and October 2021 eMARs revealed there were units of SSI documented as administered in the free-text box one time on 09/25/21 at 12:57pm; 4 units SSI administered for a FSBS of 299. Interview with the ED on 10/07/21 at 3:50pm revealed: -The new place on the eMAR to document units of SSI administered had just been added by the pharmacy that day, on 10/07/21. -There was no historical documentation available in the new column to indicate that the new MAR documentation option had been there previously. Interview with the Resident Care Coordinator (RCC) on 10/07/21 at 4:50pm revealed: -She did audits on glucometers' histories against the eMAR bi-weekly. -If she found a discrepancy, she did not look at other resident's eMARs to find where the value was documented; she would just document it in her audit log book. Interview with a second MA on 10/08/21 at 5:20pm revealed: -She documented FSBS readings in the eMAR that did not match the FSBS recorded in Resident #5's glucometer history. -She thought she sometimes forgot what the FSBS value was between doing the resident's fingerstick with the resident and documenting the result on the eMAR. Attempted telephone interview with Resident #5's primary care provider on 10/11/21 at 10:50 was unsuccessful. Refer to telephone interview with a third shift MA on 10/08/21 at 12:29pm.	D 358		

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D 358	Continued From page 37 2. Review of Resident #9's current FL2 dated 07/25/21 revealed diagnoses included diabetes mellitus. a. Review of Resident #9's physician's orders revealed there was an order dated 07/30/21 for Novolog (fast-acting insulin used to control diabetes) 5 units subcutaneously four times daily as needed for FSBS greater than 450. Recheck in one hour if FSBS not lower notify provider. Review of Resident #9's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog 5 units subcutaneously four times daily as needed for FSBS greater than 450 scheduled at 6:30am, 11:30am, 4:30pm and 8:00pm. -There were 7 FSBS documented on the eMAR that were less than 450 at 6:30am and there was documentation Novolog 5 units was administered with examples as follows: on 09/03/21 FSBS was 150; on 09/06/21 FSBS was 309; on 09/09/21 FSBS was 218; on 09/12/21 FSBS was 418; on 09/13/21 FSBS was 233; on 09/18/21 FSBS was 446; and on 09/23/21 FSBS was 228. -There were 3 FSBS documented on the eMAR at 11:30am that were less than 450 and staff documented the administration of Novolog 5 units as follows: on 09/10/21 FSBS was 361; on 09/11/21 FSBS was 358; and on 03/18/21 FSBS was 307. -There was 1 FSBS documented on the eMAR at 8:00pm that was less than 450 and staff documented the administration of Novolog 5 units on 09/27/21 and FSBS was 298. Interview with Resident #9 on 10/11/21 at 1:15pm revealed:	D 358		

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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 358	Continued From page 38 -The medication aide (MA) checked his FSBS four times daily and administered insulin. -He usually asked the MA what his FSBS was, but he was unable to say if insulin was administered for FSBS within a specific range. -He knew that some of his FSBS were high but did not know if insulin was administered for FSBS that were less than 450. Telephone interview with a shift MA on 10/08/21 at 1:31pm revealed: -When she worked, she checked the resident's FSBS at least twice per shift. -She obtained the FSBS but did not record on the eMAR until she had finished the medication pass for all residents. -She was unable to explain why Novolog 5 units was documented as administered for FSBS that were less than 450. Refer to telephone interview with a third shift MA on 10/08/21 at 12:29pm. b. Review of Resident #9's physician's order dated 07/30/21 revealed an order for Novolog (fast-acting insulin to control diabetes) 5 units subcutaneously four times daily as needed for fingerstick blood sugars (FSBS) greater than 450. Review of Resident #9's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog 5 units four times daily for FSBS greater than 450 scheduled for 6:30am, 11:30am, 4:30pm and 8:00pm. -There were FSBS documented on the eMAR 6:30am, 11:30am, 4:30pm and 8:00pm. -There were 10 FSBS readings greater than 450 in the resident's glucometer that matched the same date and time as the eMAR and required 5	D 358		

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units of Novolog and Novolog was not administered as ordered.
-Staff circled initials with documentation "withheld per doctor order" as follows:
-On 09/05/21 at 4:34pm, the glucometer reading was 535; the FSBS documented on the eMAR was 435, and required 5 units of Novolog 5, Novolog was not administered as ordered.
-On 09/05/21 at 8:37pm, the glucometer reading was 575; the FSBS documented on the eMAR was 374, and required 5 units of Novolog, Novolog was not administered as ordered.
-On 09/15/21 at 4:16pm, the glucometer reading was 484; there was no FSBS documented on the eMAR. The FSBS of 484 required 5 units of Novolog, and Novolog was not administered as ordered.
-On 09/15/21 at 7:50pm, the glucometer reading was 488; there was no FSBS documented on the eMAR. The FSBS of 488 required 5 units of Novolog, and Novolog was not administered as ordered.
-On 09/17/21 at 8:46pm, the glucometer reading was 530; the FSBS documented on the eMAR was 443, and required 5 units of Novolog, and Novolog was not administered as ordered.
-On 09/17/21 at 4:42pm, the glucometer reading was 477; the FSBS documented on the eMAR was 377, and required 5 units of Novolog, and Novolog was not administered as ordered.
-On 09/18/21 at 8:30pm, the glucometer reading was 498; the FSBS documented on the eMAR was 398, and required 5 units of Novolog, and Novolog was not administered as ordered.
-On 09/20/21 at 8:20pm, the glucometer reading was 543; the FSBS documented on the eMAR was 343, and required 5 units of Novolog, and Novolog was not administered as ordered.
-On 09/21/21 at 8:32pm, the glucometer reading was 509; the FSBS documented on the eMAR

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was 309, and required 5 units of Novolog, and Novolog was not administered as ordered.
-On 09/24/21 at 8:22pm, the glucometer reading was 482; the FSBS documented on the eMAR was 382, and required 5 units of Novolog, and Novolog was not administered as ordered.

Based on review of Resident #9's glucometer history and September 2021 eMAR the following was revealed:
-Resident #9's FSBS readings in the glucometer history ranged from 97 to 575 between 09/01/21 through 09/30/21.
-Resident #9's FSBS readings documented on the resident's eMAR for September 2021 ranged from 97 to 519 between 09/01/21 through 09/30/21.
-There were 10 FSBS glucometer readings that were greater than 450 and required 5 units of Novolog and Novolog was not administered as ordered.

Review of Resident #9's October 2021 glucometer history revealed:
-There were 2 FSBS readings greater than 450 and required 5 units of Novolog.
-The FSBS documented on the October 2021 eMAR were inconsistent with glucometer history readings and no Novolog was administered.
-The MA circled her initials and documentation "withheld per doctor order" on eMAR.
-On 10/03/21 at 8:26pm, the glucometer reading was 489; the FSBS documented on the eMAR was 389, and required 5 units of Novolog, and Novolog was administered as ordered.
-On 10/04/21 at 8:23pm, the glucometer reading was 462; the FSBS documented on the eMAR was 362, and required 5 units of Novolog, and Novolog was administered as ordered.

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D 358	Continued From page 41 Based on review of Resident #9's glucometer history and October 2021 eMAR the following was revealed: -Resident #9's FSBS readings recorded in the glucometer history ranged from 103 to 489 between 10/01/21 through 10/08/21. -Resident #9's FSBS readings documented on the resident's eMAR for October 2021 ranged from 103 to 389 between 10/01/21 through 10/08/21. -There were 2 FSBS glucometer readings for the month of October 2021 that were greater than 450 and required 5 units of Novolog and Novolog was not administered as ordered. Interview with Resident #9 on 10/11/21 at 1:15pm revealed: -He had been a diabetic for years and was considered a "brittle diabetic." -The medication aide (MA) checked his FSBS four times daily and administered insulin. -He usually asked the MA what his FSBS was and did not ask to see the glucometer. -He did not know if the FSBS given to him by the MA was accurate because he did not see the actual reading on the glucometer. Telephone interview with a MA on 10/07/21 at 5:19pm revealed: -When she worked second shift, she checked Resident #9's FSBS two times per shift at 4:30pm and 8:00pm, a little before or a little after the hour. -When she documented "withheld per doctor order" she did not administer Novolog because the order was to administer Novolog for FSBS greater than 450. -She was unable to explain why the majority of Resident #9's FSBS greater than 450 in the glucometer were documented incorrectly by her	D 358		

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on the eMAR.
-She was aware when the resident's FSBS was greater than 450 and required additional insulin.
-She thought there must be something wrong with eMAR system.
-Sometimes she wrote Resident #9's FSBS down on a piece of paper but not every time she checked his FSBS.
-Some days, depending on how busy she was, she documented the FSBS on the eMAR right after obtaining the result.
-On busy days she did not document the FSBS until she finished passing all residents their medications.
-When she did not write the FSBS down she rehearsed the FSBS in the head, then recorded it on the eMAR.
-The eMARs were audited weekly by the third shift MA to identify holes on the eMAR, medications administered and comparing glucometer readings to eMAR documentation.

Interview with Resident #9's Primary Care Provider (PCP) on 10/07/21 at 11:02am revealed:
-Resident #9's FSBS were "all over the place."
-His FSBS sometimes were high and she ordered SSI and a recheck within one hour.
-If after one hour the FSBS was still greater than 450 she wanted to be notified.

Refer to telephone interview with a third shift MA on 10/08/21 at 12:29pm.

_____

Telephone interview with a third shift MA on 10/08/21 at 12:29pm revealed:
-Every Sunday night she checked the glucometer of residents and compared with FSBS on the eMAR.
-She compared glucometer readings to the FSBS documented on the eMAR to identify if there was

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D 358	Continued From page 43 sharing of glucometers. -She had identified FSBS documented on the eMAR did not match the FSBS readings in the glucometer history. -She left a note for the Resident Care Coordinator (RCC) and the Executive Director (ED) with examples and the resident's name. -Recently, she had not checked the glucometers with the eMAR. -The last time she checked glucometers was July or August 2021. -She had been out of work for a couple of weeks in September 2021, and when she returned, she did not check the glucometer with the eMAR because the facility was short of staff and she did have the time. -She did not check the units of insulin administered or to see if staff administered the correct dosage of insulin.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances for 2 of 5 residents sampled (#2) who	D 392		

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D 392	Continued From page 44 received a narcotic pain reliever. The findings are: 1. Review of Resident #3's current hospital FL2 dated 08/09/21 revealed: -Diagnoses included diabetes mellitus, and essential hypertension (high blood pressure). -There was an order for hydrocodone-acetaminophen 5-325 (a narcotic pain reliever for moderate to severe pain and a schedule II controlled substance) one tablet every 6 hours as needed for up to 7 days. Review of Resident #3's physician's orders revealed: -There was a physician's order dated 08/09/21 for hydrocodone-acetaminophen 5-325 one tablet every 6 hours as needed for up to 7 days for moderate to severe pain. -There was a physician's order dated 08/13/21 for hydrocodone-acetaminophen 5-325 one-half (1/2) tablet twice a day for pain. -There was a physician's order dated 09/03/21 for hydrocodone-acetaminophen 5-325 one-half (1/2) tablet twice a day for pain. Review of Resident #3's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry starting on 08/09/21 for hydrocodone-acetaminophen 5-325 one tablet every 6 hours as needed for up to 7 days for moderate to severe pain, scheduled for as needed (prn) administration. The order was discontinued on 08/15/21. -There was an entry starting on 08/13/21 for hydrocodone-acetaminophen 5-325 one-half (1/2) tablet twice a day for pain scheduled for administration at 8:00am and 8:00pm daily.	D 392		

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D 392	Continued From page 45 Review of Resident #3's controlled substance count sheet (CSCS) received from the contracted pharmacy provider revealed: -There was a CSCS dated 08/09/21 for hydrocodone-acetaminophen 5-325 one tablet every 6 hours as needed for up to 7 days for moderate to severe pain for a quantity of 8 tablets dispensed on 08/09/21 and received by a facility representative on 08/09/21. -There was a CSCS dated 08/16/21 for hydrocodone-acetaminophen 5-325 one-half (1/2) tablet twice a day for pain for a quantity of 60 doses (30 of 1/2 tablets) received by a facility representative on 08/16/21. Review of Resident #3's CSCS for 8 tablets of hydrocodone-acetaminophen 5-325 tablets dispensed on 08/09/21 compared to Resident #3's August 2021 eMAR revealed: -On 08/12/21 (no time listed,) one tablet was signed out on the CSCS with no documentation for as needed administration on the eMAR. -On 08/15/21 (no time listed), one tablet was signed out on the CSCS with no documentation for as needed administration on the eMAR. There was documentation for administration listed on the August 2021 eMAR for one-half tablet twice a day at 8:00am on 08/15/21. Based on record review there were 2 hydrocodone-acetaminophen 5-325 tablets not properly accounted for from the 8 tablets dispensed on 08/09/21. Review of Resident #3's CSCS received from the contracted pharmacy provider dated 08/16/21 for hydrocodone-acetaminophen 5-325 one-half (1/2) tablet twice a day for pain for a quantity of 60 doses (30 of 1/2 tablets) received by a facility	D 392		

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representative on 08/16/21 compared to the August 2021 eMAR revealed on 08/29/21 one dose (1/2 tablet) of hydrocodone-acetaminophen 5-325 was documented as administered at 8:00pm and was not signed out on the CSCS.

Review of Resident #3's September 2021 and October 2021 eMARs revealed there was an entry for hydrocodone-acetaminophen 5-325 one-half (1/2) tablet twice a day for pain scheduled for administration at 8:00am and 8:00pm daily.

Continued review of Resident #3's CSCS received from the contracted pharmacy provider dated 08/16/21 for hydrocodone-acetaminophen 5-325 one-half (1/2) tablet twice a day for pain for a quantity of 60 doses (30 of 1/2 tablets) compared to Resident #3's September 2021 eMAR revealed:
-On 09/06/21 at 8:00am, one dose (1/2 tablet) of hydrocodone-acetaminophen 5-325 was documented as administered on the eMAR and was not signed out on the CSCS.
-On 09/07/21 at 8:00am, one dose (1/2 tablet) of hydrocodone-acetaminophen 5-325 was documented as administered on the eMAR and was not signed out on the CSCS.
-On 09/22/21 at 8:00am, one dose of hydrocodone-acetaminophen 5-325 was documented as administered on the eMAR and was not signed out on the CSCS.

Based on record review there were 4 hydrocodone-acetaminophen 5-325 tablets one-half tablet doses not properly accounted for from the 30 tablets dispensed on 08/16/21.

Review of the CSCS for 60 doses of hydrocodone-acetaminophen 5-325 one-half (1/2)

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tablet twice a day for pain for a quantity of 60 doses received by a facility representative on 09/17/21 compared to Resident #3's September 2021 eMAR revealed:
-On 09/22/21 at 8:00am, one dose of hydrocodone-acetaminophen 5-325 was documented as administered on the eMAR and was not signed out on the CSCS.
-On 10/01/21 at 8:00pm, one dose of hydrocodone-acetaminophen 5-325 was documented as administered on the eMAR and was not signed out on the CSCS by the same staff member documenting administration on the eMAR.

Based on record review there were 4 hydrocodone-acetaminophen 5-325 tablets one-half tablet doses not properly accounted for from the 60 doses dispensed on 09/17/21.

Observation of Resident #3's hydrocodone-acetaminophen 5-325 on hand for administration revealed the remaining quantity matched the doses documented as administered on the eMARs and doses signed out on the CSCS for 60 doses dispensed on 09/17/21.

Telephone interview with a pharmacist from the contracted pharmacy on 10/11/21 at 10:10am revealed:
-The pharmacy sent the CSCS with medications when they were sent from the pharmacy to the facility.
-The facility was responsible to use the CSCS along with the residents' eMARs to assist with tracking receipt and administration of controlled medications.

Telephone interview a medication aide (MA) on 10/12/21 at 11:00am revealed:

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-She documented administration on the eMAR and signed the CSCS as she administered medication, before going to a new resident.
-She did not think all MAs did the same way, because some signed out controlled medications on the CSCS at the end of their shift.
-The MAs were responsible to ensure the CSCS and the inventory on hand matched prior to leaving their shift.
-The MAs ending their shift were supposed to reconcile the quantity of controlled medications quantity on hand with the CSCS with the oncoming shift prior to leaving their shift.
-There had not been a time recently when she recognized a variance between the CSCS and the on-hand medications.
-If the pill count was off, the MA would be responsible for reporting the discrepancy to either the Resident Care Coordinator (RCC) or the Executive Director (ED).

Attempted telephone interview with the RCC on 10/11/21 at 10:00 and 10/12/21 at 9:00 was unsuccessful.

Refer to interview with the Executive Director (ED) on 10/11/21 at 12:00pm.

2. Review of Resident #2's current FL2 dated 07/21/21 revealed:
-Diagnoses included Parkinson's disease and chronic pain.
-There was an order for Tramadol (a schedule IV narcotic used to treat moderate pain) 100mg twice daily as needed (PRN).

Telephone interview with a representative from the contracted pharmacy on 10/08/21 at 10:10am revealed:
-The pharmacy had sent the Tramadol to the

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facility as half tablets in the bubble packs when the medication had been ordered for a half tablet twice daily on 08/13/21.
-They had dispensed Tramadol to the facility as follows:
-Tramadol 50mg tablet on 09/30/21 with a quantity of 20 tablets (take 1 tablet twice daily for pain).
-Tramadol 50mg tablet on 08/20/21 with a quantity of 60 tablets (take 1 tablet twice daily for pain).
-Tramadol 50mg tablet on 08/13/21 with a quantity of 30 tablets (take ½ tablet twice daily for pain).
-Tramadol 50mg tablet on 08/11/21 with a quantity of 20 tablets (take 1 tablet every 6 hours PRN).

Observation of medication on hand for Resident #2's Tramadol revealed they had one medication card for Tramadol 50mg take one tablet twice daily for pain.

Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Tramadol 50mg take 1 tablet every 6 hours PRN with a start date of 08/11/21 and an end date of 08/13/21 and there were no documentation Tramadol was administered on the August 2021 eMAR or controlled substance count sheet (CSCS).
-There was an entry for Tramadol 50mg take one half tablet twice daily at 8:00am and 8:00pm for pain with a start date of 08/13/21 and a discontinue date of 08/20/21 and medication was documented as administered as ordered in this time frame.
-There was an entry for Tramadol 50mg take one tablet twice daily for pain at 8:00am and 8:00pm

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with a start date of 08/20/21 and medication was documented as administered as ordered .

Review of Resident #2's (CSCS) for Tramadol compared to the August 2021 eMAR revealed:
-On 08/15/21 at 9:30am, Tramadol was signed out on two different CSCS sheets: Tramadol 50mg 1 tablet every 6 hours PRN and Tramadol 50mg half tablet twice daily.
-On 08/16/21 at 8:00pm, Tramadol was signed out on two different CSCS sheets: Tramadol 50mg 1 tablet every 6 hours PRN and Tramadol 50mg half tablet twice daily.
-On 08/18/21 at 8:00am, Tramadol 50mg was documented as administered on eMAR for a half tablet, but signed out on CSCS sheet for 1 full tablet. The order for a full tablet had been discontinued on 08/13/21.
-On 08/20/21 at 8:00pm, the staff who signed Tramadol out on the CSCS sheet did not match the staff who documented administration on the eMAR.
-On 08/21/21 at 8:00am, Tramadol was documented as administered on the eMAR but not signed out on the CSCS sheet.
-On 08/28/21 and 08/30/21 at 8:00am, Tramadol was signed out on two different CSCS sheets: Tramadol 50mg half tablet twice daily and Tramadol 50mg one full tablet twice daily.

Review of Resident #2's September and October 2021 eMAR revealed:
-There was an entry for Tramadol 50mg take 1 tablet twice daily for pain at 8:00am and 8:00pm.
-Tramadol 50mg was documented as administered as ordered at 8:00am and 8:00pm from 09/01/21 to 10/06/21.

Review of Resident #2's CSCS sheet for Tramadol compared to the September and

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D 392	Continued From page 51 October 2021 eMARs revealed: -On 09/17/21 at 8:00pm, the staff who signed Tramadol out on the CSCS sheet did not match the staff who documented administration on the eMAR. -On 10/04/21 at 8:00am, the staff who signed Tramadol out on the CSCS sheet did not match the staff who documented administration on the eMAR Interview with the medication aide (MA) on 10/08/21 at 4:35pm revealed: -She reviewed CSCS sheets against eMARs where she documented Tramadol as signed out on the CSCS, but another MA documented the administration in the the eMAR, and she could not explain why. -She thought sometimes the charting system did not switch profiles when she logged in, causing her to document under another MA's initials. Interview with the MA/Supervisor on 10/12/21 at 10:50am revealed: -When she was administering controlled substances such as Tramadol, she would review the order, then sign out the medication on the CSCS sheet, then administer the medication, and document administration on the eMAR. -Staff would do a pill counts together between shifts. -If the pill count did not match the expected number on the CSCS sheet, the off going MA would have to fix the count before ending their shift. -If the pill count was off, the MA would be responsible for reporting the discrepancy to either the Resident Care Coordinator (RCC) or the Executive Director. Attempted telephone interview with the RCC on	D 392		

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D 392	Continued From page 52 10/11/21 at 10:00 and 10/12/21 at 9:00 was unsuccessful. Refer to interview with the Executive Director (ED) on 10/11/21 at 12:00pm. _____ Interview with the ED on 10/11/21 at 12:00pm revealed: -The CSCS sheets were maintained for residents by the month the sheets were completed. -The facility had organized the CSCS for easier auditing. -The RCC would be responsible for auditing the CSCS prior to filing the sheets.	D 392		
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 as related to health care, and Adult Care Home infection prevention requirements. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to ensure the provider was notified for 2 of 6 sampled residents (#1 and	D912		

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D912	Continued From page 53 #3) related to low or elevated blood sugars with hypoglycemic episodes (#3), and not obtaining an anti-depressant medication following a provider consultation (#1). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 2. Based on observation, record reviews, and interviews, the facility failed to ensure physician's orders were implemented for 4 of 5 sampled residents (#2, #3, #4, and #9) with an order for fingerstick blood sugars (FSBS) four times daily (#4) an order to recheck FSBS and notify the physician (#9), an order to check blood pressure and heart rate daily and not rechecking FSBS when blood sugars were greater than 450 (#3), and an order for thrombo-embolus deterrent (TED) hose (#2). [Refer to Tag D276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation)]. 3. Based on observation, record reviews, and interviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to ensure proper infection control procedures for the use of glucometers for 5 of 7 sampled residents (#4, #5, #7, #8, and #9) with diabetes and orders for fingerstick blood sugar checks, resulting in sharing glucometers between residents. [Refer to Tag 932, G.S.131D-4.4A(b) Adult Care Home Infection Prevention Requirements (Unabated Type B Violation).].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements	D932		

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D932	Continued From page 54 (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.	D932		

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This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE B VIOLATION

Based on these findings, the previous Type B Violation was not abated.

Based on observation, record reviews, and interviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to ensure proper infection control procedures for the use of glucometers for 5 of 7 sampled residents (#4, #5, #7, #8, and #9) with diabetes and orders for fingerstick blood sugar checks, resulting in sharing glucometers between residents.

The findings are:

Observation of fingerstick blood sugar (FSBS)

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testing by a morning medication aide (MA) on 10/07/21 at 11:50am revealed:
-The MA donned gloves, removed a plastic storage case containing a zipper pouch with a Brand A glucometer. The plastic container, zippered pouch, and glucometer were labeled with the same name matching the resident identified for FSBS testing.
-The MA used proper infection prevention techniques to obtain the FSBS.
-The MA disposed of the single use lancing device and test strip in a biohazard waste container and the gloves and alcohol swabs in the trash.

Review of the CDC guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instruction. If the manufacturer does not list disinfecting information, then the glucometer should not be shared between residents.

Review of manufacturer's user guide for Brand A glucometer revealed:
-The Brand A glucometer was for one person use only. "Do not use on multiple patients".
-"All parts of your blood glucose monitoring system could carry blood-borne pathogens after use, even after cleaning and disinfecting."

Interview with the Executive Director (ED) on 10/07/21 at 4:00pm revealed the facility policy was for all residents receiving FSBS to have their own glucometer.

1. Review of Resident #7's current FL2 date 07/16/21 revealed:

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D932	Continued From page 57 -Diagnoses included heart failure and diabetes mellitus Type 2. -There was an order for fingerstick blood sugar (FSBS) three times a day before meals. Review of Resident #7's physician orders dated 08/13/21 revealed an order to Inject 3 units of Humalog subcutaneously 4 times daily as needed for blood sugar greater than 450 and recheck in one hour, if not lower notify physician. Observation of the back hall medication cart on 10/06/21 at 2:44pm revealed: -Resident #7 had a zippered pouch with a glucometer, labeled with his name. -Resident #7 had a Brand A, single use only glucometer. Review of Resident #7's FSBS values recorded in the history of Resident #7's glucometer revealed: -FSBS values recorded in the history of the glucometer were not consistent with FSBS readings documented on the resident's September 2021 and October 2021 electronic medication administration record (eMAR). -There were multiple FSBS readings within a short period of time recorded in Resident #7's glucometer's history on 09/07/21. Review of Resident #7's September 2021 eMAR revealed: -There was an entry for FSBS checks four times a day scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm. -FSBS values were documented on the eMAR 4 times a day from 09/07/21 to 09/10/21 and from 09/27/21 to 09/30/21. Review of FSBS values recorded in the history of Resident #7's glucometer compared to the FSBS	D932		

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D932	Continued From page 58 values documented on the September 2021 eMAR revealed: -Resident #7 was documented out of the facility on family leave from 09/11/21 to 09/26/21 with 37 FSBS values recorded in the glucometer's history. -There were 32 opportunities for FSBS values in September 2021 documented on the eMAR when the resident was in the facility from 09/07/21 to 09/30/21. -There were 32 FSBS values recorded in the history of Resident #7's glucometer. -There were 12 FSBS values recorded in the history of the glucometer that did not match FSBS values documented on the September 2021 eMAR. (Example: On 09/30/21 at 11:30am FSBS reading documented on the eMAR was 356 and FSBS recorded in the history of the glucometer was 327). Examples of additional values recorded in the history of Resident #7's glucometer in a short period of time but not documented on Resident #7's September 2021 eMAR were as follows: -On 09/07/21 at 4:30pm, FSBS=239 was documented on Resident #7's eMAR but was not recorded in the history of Resident #7's glucometer. -On 09/07/21 at 4:46pm, FSBS= 340 was recorded in the history of Resident #7's glucometer and not documented on the resident's eMAR at 4:30pm but was consistent with FSBS reading documented on another resident's (#9) eMAR on 09/07/21 at 4:30pm and not recorded in the history of the other resident's glucometer. -On 09/07/21 at 4:57pm, FSBS=203 was recorded in the history of Resident #7's glucometer but not documented on the resident's eMAR. -On 09/07/21 at 5:02pm, FSBS=215 was	D932		

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recorded in the history of Resident #7's glucometer but not documented on the resident's eMAR but was consistent with FSBS reading documented on another resident's (#5) eMAR on 09/07/21 at 4:30pm and not recorded in the history of the other resident's glucometer.

Review of Resident #'7's September 2021 eMAR revealed:
-There was an entry for FSBS checks four times a day scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm.
-FSBS values were documented on the eMAR 4 times a day from 10/01/21 to 10/06/21.

Review of FSBS values recorded in the history of Resident #7's glucometer compared to the FSBS values documented on the October 2021 eMAR revealed:
-There were 22 opportunities for FSBS checks from 10/01/21 to 10/06/21 at 11:30pm.
-There were 19 FSBS reading recorded in the history of Resident #7's glucometer.
-On 10/01/21 at 8:00pm, FSBS= 236 was documented on the eMAR but no corresponding FSBS reading was recorded in the history of Resident #7's glucometer.
-On 10/02/21 at 8:00pm, FSBS= 358 was documented on the eMAR but no corresponding FSBS reading was recorded in the history of Resident #7's glucometer.
-On 10/03/21 at 8:00pm, FSBS= 328 was documented on the eMAR but no corresponding FSBS reading was recorded in the history of Resident #7's glucometer.
-On 10/04/21 at 8:00pm, FSBS= 324 was documented on the eMAR but no corresponding FSBS reading was recorded in the history of Resident #7's glucometer.
-On 10/02/21 at 4:28pm, FSBS= 242 was an

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additional FSBS reading recorded in the history of Resident #7's glucometer in a short period of time but not documented on Resident #7's October 2021 eMAR.
-On 10/02/21 at 4:48pm, FSBS= 214 was documented on the eMAR and corresponded to FSBS reading recorded in the history of the resident's glucometer.

Interview with Resident #7 on 10/11/21 at 10:30am revealed:
-Staff checked his FSBS 4 times a day.
-He had been out of the facility for a couple of weeks in September 2021 visiting his family and took his glucometer with him.
-He thought staff always used his glucometer to check his FSBS.

Refer to interview with the Resident Care Coordinator (RCC) on 10/07/21 at 5:00pm.

Refer to interview with the Executive Director (ED) on 10/07/21 at 4:00pm.

Refer to telephone interview with a third shift medication aide (MA) on 10/08/21 at 12:29pm.

Refer to telephone interview with a medication aide (MA) on 10/12/21 at 10:50am.

2. Review of Resident #8's current FL2 date 03/31/21 revealed diagnoses included diabetes mellitus Type 2.

Review of Resident #8's physician's orders dated 08/05/21 revealed there was an order for fingerstick blood sugar (FSBS) before meals and at bedtime.

Observation of the front hall medication cart on

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D932	Continued From page 61 10/11/21 at 2:00pm revealed: -Resident #8 had a zippered pouch with a glucometer, labeled with his name. -Resident #8 had a Brand A, single use only glucometer. Review of Resident #'8's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks before meals and at bedtime scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm. -There was documentation Resident #8 was out of the facility from 09/25/21 to 09/30/21. Review of FSBS values recorded in the history of Resident #8's glucometer compared to the FSBS values documented on the September 2021 eMAR revealed: -On 09/20/21 at 6:08am, FSBS=135 was recorded in the history of Resident #8's glucometer and corresponded to FSBS reading documented on the resident's eMAR. -On 09/20/21 at 4:30pm, FSBS=317 was documented on the eMAR but was not recorded in the history of Resident #8's glucometer. -On 09/22/21 at 4:30pm, FSBS=279 was documented on the eMAR but was not recorded in the history of Resident #8's glucometer. -On 09/22/21 at 8:00pm, FSBS=194 was documented on the eMAR but was not recorded in the history of Resident #8's glucometer. -On 09/24/21 at 7:29pm, FSBS=192 was recorded in the history of Resident #8's glucometer but not documented on the eMAR. -On 09/24/21 at 8:00pm, FSBS=184 was documented on the eMAR but was not recorded in the history of Resident #8's glucometer. Review of Resident #'8's October 2021 electronic	D932		

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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
D932	Continued From page 62	D932		

medication administration record (eMAR) revealed:
-There was an entry for FSBS checks before meals and at bedtime scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm.
-There were no FSBS readings documented on the eMAR from 10/01/21 to 10/08/21.

Review of the history of Resident #8's glucometer on 10/08/21 for the month of September 2021 compared to the resident's September 2021 eMAR revealed:
-On 10/04/21 at 3:00pm, FSBS=46 was recorded in the history of Resident #8's glucometer with a symbol indication the reading was for a control solution when Resident #8 was in the hospital.
-On 10/06/21 at 6:27am, FSBS=201 was recorded in the history of Resident #8's glucometer when Resident #8 was in the hospital.

Interview with the Executive Director on 10/08/21 at 3:00pm revealed:
-Resident #8 was sent to the hospital on 09/25/21 around lunch time.
-Resident #8 was currently at a rehabilitation facility.
-She did not know why Resident #8 would have any FSBS values recorded in the history of her glucometer since she had not been at the facility since 09/25/21.
-Staff should not be using her glucometer to check any other residents' FSBS.

Refer to interview with the Resident Care Coordinator (RCC) on 10/07/21 at 5:00pm.

Refer to interview with the Executive Director (ED) on 10/07/21 at 4:00pm.

Refer to telephone interview with a third shift

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D932	Continued From page 63 medication aide (MA) on 10/08/21 at 12:29pm. Refer to telephone interview with a medication aide (MA) on 10/12/21 at 10:50am. 3. Review of Resident #9's current FL2 dated 07/25/21 revealed diagnoses included diabetes mellitus. Review of Resident #9's physician's orders revealed there was an order dated 07/30/21 for Novolog 5 units subcutaneously four times daily as needed for FSBS greater than 450. Recheck in one hour if FSBS not lower notify provider. Observation of the back hall medication cart on 10/06/21 at 2:44pm revealed: -Resident #9 had a zippered pouch with a glucometer, labeled with his name. -Resident #9 had a Brand A, single use only glucometer. Review of Resident #9's FSBS values recorded in the history of Resident #9's glucometer revealed FSBS values recorded in the history of the glucometer were not consistent with FSBS readings documented on the resident's September 2021 and October 2021 electronic medication administration record (eMAR). Review of Resident #9's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog 5 units subcutaneously four times daily as needed for FSBS greater than 450 scheduled at 6:30am, 11:30am, 4:30pm and 8:00pm. -FSBS values documented on the resident's eMAR were inconsistent with FSBS reading in the history of Resident #9's glucometer.	D932		

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D932	Continued From page 64 Review of FSBS readings recorded in the history of Resident #9's glucometer for the month of September 2021 compared to the resident's September 2021 eMAR revealed: -On 09/07/21 at 6:30am, FSBS= 210 was documented on the eMAR and recorded in the history of the resident's glucometer. -On 09/07/21 at 11:30am, FSBS= 241 was documented on the eMAR and recorded in the history of the resident's glucometer. -On 09/07/21 at 4:30pm, FSBS= 340 was documented on the eMAR and no corresponding FSBS reading was recorded in the history of Resident #9's glucometer; On 09/07/21 at 4:46pm, FSBS= 340 was recorded in the history of Resident #7's glucometer and not documented on the resident's eMAR at 4:30pm but was consistent with FSBS reading documented on another resident's (#9) eMAR on 09/07/21 at 4:30pm but not recorded in the history of the other resident's (#9) glucometer. Interview with Resident #9 on 10/11/21 at 1:15pm revealed; -He had been a diabetic for years and was considered a brittle diabetic. -The MA checked his FSBS four times daily and administered insulin 4 maybe 5 times daily, but he was not sure. -He usually asked the MA what his FSBS was, but his memory did not retain the FSBS very long. Refer to interview with the Resident Care Coordinator (RCC) on 10/07/21 at 5:00pm. Refer to interview with the Executive Director (ED) on 10/07/21 at 4:00pm. Refer to telephone interview with a third shift	D932		

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D932	Continued From page 65 medication aide (MA) on 10/08/21 at 12:29pm. Refer to telephone interview with a medication aide (MA) on 10/12/21 at 10:50am. 4. Review of Resident #5's current FL2 dated 05/31/21 revealed: -Diagnoses included type 2 diabetes mellitus and long-term use of insulin. -There was a physician's order for Humalog (fast-acting insulin used to lower elevated blood sugar levels) sliding scale insulin (SSI) three times a day before meals. Review of Resident #5's physician's orders signed 06/09/21 revealed there was an order for Humalog SSI as follows: Inject sliding scale before meals: 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, 401-450= 10 units, 451-500= 12 units, 501-999= 14 units. Observation of the back hall medication cart on 10/06/21 at 2:44pm revealed: -Resident #5 had a zippered pouch with a glucometer, labeled with his name. -Resident #5 had a Brand A, single use only glucometer. Review of Resident #5's fingerstick blood sugar (FSBS) values recorded in the history of Resident #5's glucometer revealed: -FSBS values recorded in the history of the glucometer were not consistent with FSBS readings documented on the resident's September 2021 and October 2021 electronic medication administration record (eMAR). -There were multiple FSBS readings within a short period of time recorded in Resident #7's glucometer's history on 09/07/21.	D932		

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D932	Continued From page 66 Review of Resident #5's September electronic medication administration record (eMAR) revealed there was an entry for inject Humalog SSI before meals scheduled at 6:30am, 11:30am, and 4:30pm. Review of FSBS readings recorded in the history of Resident #5's glucometer on 10/06/21 at 11:05am compared to the September 2021 (eMAR) revealed: -From 09/05/21 to 10/06/21 there were 7 opportunities for FSBS readings missing from his glucometer's history but FSBS values documented on eMAR with examples as follows: -On 09/24/21 at 4:30pm, FSBS=119 was documented on the eMAR with no FSBS recorded in the glucometer's history. -On 09/22/21 at 4:30pm, FSBS=127 was documented on the eMAR with no FSBS recorded in the glucometer's history. -On 09/07/21 at 4:30pm, FSBS=215 was documented on the eMAR with no FSBS recorded in the glucometer's history; On 09/07/21 at 5:02pm, FSBS=215 was recorded in the history of another resident's (#7) glucometer and not documented on the other resident's (#7)eMAR, but was consistent with FSBS reading documented on Resident #5's eMAR on 09/07/21 at 4:30pm and not recorded in the history of Resident #5's glucometer. -On 09/07/21 at 11:30am, FSBS=222 was documented on the eMAR with no FSBS recorded in the glucometer's history. Continued review of FSBS readings recorded in the history of Resident #5's glucometer on 10/06/21 at 11:05am compared to the September 2021 eMAR revealed: -Between the dates of 09/05/21 and 10/06/21	D932		

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D932	Continued From page 67	D932		

there were 3 additional FSBS readings recorded in the glucometer's history, but not documented on the eMAR, as follows:
-On 09/27/21, at 5:25pm FSBS=319 (not documented on the eMAR), at 5:30pm FSBS=238, at 12:02pm FSBS=264, and at 5:38am FSBS=147.
-On 09/20/21, at 4:43pm FSBS=209, at 4:17pm FSBS=455 (not documented on the eMAR), at 11:26am FSBS=162, and at 6:47am FSBS=162.
-On 09/09/21, at 9:44pm FSBS=190 (not documented on the eMAR), at 4:20pm FSBS=237, at 11:14am FSBS=175, and at 5:45am FSBS=127.

Attempted telephone interview with Resident #5's primary care provider (PCP) on 10/11/21 at 10:50am was unsuccessful.

Refer to interview with the Resident Care Coordinator (RCC) on 10/07/21 at 5:00pm.

Refer to interview with the Executive Director (ED) on 10/07/21 at 4:00pm.

Refer to telephone interview with a third shift medication aide (MA) on 10/08/21 at 12:29pm.

Refer to telephone interview with a medication aide (MA) on 10/12/21 at 10:50am.

5. Review of Resident #4's current FL2 dated 09/03/21 revealed diagnoses included diabetes mellitus type II.
-There was an order for Novolog (fast-acting insulin to control diabetes) 6 units subcutaneously three times daily before meals. Hold if less than 100 or resident not eating.

Review of Resident #4's September 2021

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D932	Continued From page 68 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog 6 units three times daily before meals scheduled for 6:30am, 11:30am and 4:30pm. -There was opportunity to obtain 30 FSBS at 4:30pm from 09/01/21 through 09/30/21. -There were 30 FSBS documented on the eMAR from 09/01/21 through 09/30/21. -Twenty-one of 30 FSBS documented on the September 2021 eMAR at 4:30pm were inconsistent with FSBS readings in the history of Resident #4's glucometer with examples as follows: -On 09/02/21 FSBS was 219, not in resident's glucometer history. -On 09/03/21 FSBS was 159, not in resident's glucometer history. -On 09/04/21 FSBS was 228, not in resident's glucometer history. -On 09/05/21 FSBS was 238, not in resident's glucometer history. -On 09/07/21 FSBS was 126, not in resident's glucometer history. -On 09/10/21 FSBS was 262, not in resident's glucometer history. -On 09/11/21 FSBS was 150, not in resident's glucometer history. -On 09/13/21 FSBS was 169, not in resident's glucometer history. -On 09/14/21 FSBS was 175, not in resident's glucometer history. -On 09/15/21 FSBS was 202, not in resident's glucometer history. -On 09/17/21 FSBS was 194, not in resident's glucometer history. -On 09/18/21 FSBS was 292, not in resident's glucometer history. Review of FSBS results recorded in the history of	D932		

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Resident #4's glucometer compared to the FSBS documented on the September 2021 eMAR revealed:
-There were 25 FSBS readings in the glucometer history from 09/01/21 through 09/30/21 that were not documented on the September 2021 eMAR with examples as follows:
-On 09/06/21 at 8:42pm, FSBS in the glucometer history was 188, but not documented on the eMAR.
-On 09/14/21 at 4:25pm, FSBS in the glucometer history was 235, but not documented on the eMAR.
-On 09/15/21 at 4:26pm, FSBS in the glucometer history was 206, but not documented on the eMAR.
-On 09/15/21 at 6:32pm, FSBS in the glucometer history was 282, but not documented on the eMAR.

Based on review of FSBS documented on Resident #4's September and October 2021 eMAR and FSBS in the resident's glucometer history for September and October 2021, the FSBS documented on the eMAR did not match FSBS obtained using the resident's glucometer and could not be matched with other residents' glucometer histories.

Based on observation, record review and interview it was determined that Resident #4 was not interviewable.

Telephone interview with a MA on 10/07/21 at 5:19pm revealed:
-When she worked second shift, she checked Resident #4's FSBS once on her shift.
-She was unable to explain why the majority of Resident #4's FSBS at 4:30pm obtained by her did not match the FSBS readings in the resident's

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D932	Continued From page 70 glucometer. -Previously, there was a problem with the eMAR system not recording FSBS documented. -She had reported it to the Resident Care Coordinator (RCC) a couple of months ago but she was still unable to explain why the eMAR and glucometer did not match. -Each resident had their own glucometer and pouch that was labeled with the resident's name. -When she went to the resident's room she took the pouch labeled with Resident #4's name. -She checked the FSBS in the room. -Some days she wrote the FSBS on a piece of paper but not every day, most days she forgot. -Some days she documented the FSBS right away in the eMAR, but most days she waited until she finished passing medications to all residents. -The eMARs were audited weekly by the third shift MA to identify holes on the eMAR, medications administered as ordered and the MA compared glucometer readings to the eMAR documentation to identify sharing of glucometers between residents. Refer to interview with the Resident Care Coordinator (RCC) on 10/07/21 at 5:00pm. Refer to interview with the Executive Director (ED) on 10/07/21 at 4:00pm. Refer to telephone interview with a third shift medication aide (MA) on 10/08/21 at 12:29pm. Refer to telephone interview with a medication aide (MA) on 10/12/21 at 10:50am. _____ Interview with the RCC on 10/07/21 at 5:00pm revealed: -The facility policy was for each resident to have a glucometer assigned to the resident.	D932		

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D932	Continued From page 71 -The residents' glucometers were not supposed to be shared between residents. -She had been conducting random audits twice a week comparing the FSBS readings recorded in the residents' glucometer histories to the FSBS readings staff documented on the eMARs. -She had noted there were a few times when there were missing FSBS readings or additional FSBS readings recorded in the history of a few residents' glucometer histories but was not sure how to use the information or look for missing FSBS readings in other residents' glucometer histories and documented on their eMARs. -She replaced a couple of glucometers that seemed to be not recording FSBS readings that staff said they had obtained. -She had identified a few extra readings in residents' glucometer histories but not multiple FSBS readings in a short period of time in her audits. Interview with the ED on 10/07/21 at 4:00pm revealed: -The facility policy was for all residents receiving FSBS to have their own glucometer. -The MAs had received in-service training since June 2021 regarding not sharing glucometers between residents. -The RCC was responsible to audit the glucometers related to monitoring the readings recorded in the glucometer histories compared to the FSBS readings documented on the eMARs for proper and accurate documentation and identifying signs of sharing glucometers between residents. -It was her understanding that, according to the facility's glucometer supplier representative, the Brand A could be disinfected with an Environmental Protection Agency approved disinfecting wipe, but staff should not be sharing	D932		

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glucometers between residents.
-She had spoken to the representative regarding suspected problems with the Brand A glucometers not recording FSBS readings in the history and replaced a couple of glucometers for such an issue.
-She did not know there were additional FSBS readings and missing FSBS readings in residents' glucometer histories at the present time.

Telephone interview with a third shift MA on 10/08/21 at 12:29pm revealed:
-Every Sunday night she checked the glucometer of residents ordered FSBS.
-She compared glucometer readings to FSBS documented on the eMAR to identify if there was sharing of glucometers between residents.
-When she checked a resident's eMAR and glucometer readings she had identified FSBS documented on the eMAR which did not match the FSBS readings in the glucometer history.
-She left a note for the RCC and the ED with examples and the resident's name.
-Recently, she had not checked the glucometer histories with the eMAR.
-The last time she checked glucometer histories was July or August 2021.
-She had been out of work for a couple of weeks in September 2021, and when she returned, she did not check the glucometer histories with the eMARs because the facility was short of staff and she did have time.
-She did not check the units of insulin administered or to see if staff administered the correct dosage.
-She crossed checked glucometer readings with other residents to identify sharing of glucometers between residents.

Telephone interview with a MA on 10/12/21 at

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D932	Continued From page 73 10:50am revealed: -The facility's policy was each resident had their own glucometer. -She cleaned each glucometer before and after each use. -The glucometers and cases were all labeled with residents' names. -She had never found the wrong glucometer in a resident's case. _____ The facility failed to implement infection control procedures consistent with CDC guidelines resulting in sharing glucometers between residents which placed residents at risk for possible exposure to bloodborne pathogens diseases. This failure was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S.131D-34 on 10/07/21 for this violation.	D932		