Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011296	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted a follow-up survey on 09/13/22 though 09/15/22.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure follow-up to meet the needs of 1 of 3 sampled residents (Resident #1) related to obtaining prescription glasses. The findings are: Review of Resident #1's current FL2 dated 02/10/22 revealed diagnoses included traumatic brain injury, seizures, bi-polar disorder, anxiety and depression. Interview with Resident #1 on 09/13/22 at 9:00am revealed: -He was waiting on glasses that were ordered when he went to the ophthalmologist over a month ago. -The glasses were covered by his insurance and the ophthalmologist's office was supposed to call the facility when the glasses came in. Review of Resident #1's record revealed: -He had an appointment with his ophthalmologist on 07/28/22 and glasses were prescribed. -There was no documentation the glasses were ordered.	D 273	After the initial Appointment. The SIC and Resident were told they were Finished and Could go. When no one Called The SIC Called the Opnthamalgist re. Resident Glasses. She was told it could be another 2 weeks. On 9/18/2022 SIC took Resident back to Ophthamalgist re. glasses on 9/27/2022 Opthamalgist office Called The glasses were in however they were not covered by Medicaid, and he would not be eligable for new Ones until July 2023	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa O'Kelley — TITLE: Administrator — (X6) DATE: 10/26/22

Reviewed and acknowledged LSB 10/31/22

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D 273	Continued From page 1 Telephone interview with an optical lab assistant from Resident #1's ophthalmologist's optical center on 09/13/22 at 2:59pm revealed: -Resident #1 saw the ophthalmologist on 07/28/22 and glasses were prescribed. -When a patient checked out after their appointment with the physician, they were instructed to go to the optical center next door if glasses were prescribed at the appointment. -Resident #1 needed to pick out the frames and be measured for the glasses before they could be ordered. -There was no documentation the glasses were ordered at the optical center. -There was no documentation anyone called to check on the status of the glasses. Interview with a Medication Aide (MA) on 09/13/22 at 3:15pm revealed: -Glasses were prescribed when she took Resident #1 to the ophthalmologist. -No one informed her that she needed to order the glasses, so she assumed the glasses were being ordered. -She called the ophthalmologist's office last week to check on the status of the order and was told it could take 2 more weeks. -She did not know who she spoke with and she did not document the call in Resident #1's record. Another interview with Resident #1 on 09/13/22 at 3:21pm revealed: -After his appointment with the doctor he was not instructed to go to the optical center to order his glasses. -He thought the glasses had been ordered. -He did not know if the MA called anyone to check on the order.	D 273	The resident refused to pay for glasses. SIC contacted the guardian she refused to pay the guardian contacted the father. The Resident said his father Also refused to pay for new glasses. The resident then Ask For over the counter reading glasses. We supplied those to him at no charge In the future the SIC will ask befor Leaving the physicians office if there are any other instructions she should be Aware of. The SIC will document in the future when a follow up Call is placed to the physician	10/3/22

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D 273	Continued From page 2 Interview with the Administrator on 09/13/22 at 4:52pm revealed: -She was unaware Resident #1 was prescribed glasses. -The MA told her earlier today (09/13/22) she called last week to inquire about the status of the order. -The MA did not know to ask questions about the ordering process.	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: The facility failed to implement physician orders for 3 of 4 sampled residents (#1, #2 and #3) related to obtaining fingerstick blood sugars (#1 and #3) and monthly blood pressures (#2). The findings are: 1. Review of Resident #3's current FL2 dated 07/07/22 revealed: -Diagnoses included diabetes mellitus type 2. -There was an order for fingerstick blood sugar (FSBS) checks before each meal and at bedtime. Review of Resident #3's August 2022 FSBS Monitoring Log revealed: -There was no documentation FSBSs were	D 276	To assure monthly blood pressures and Weights are being Taken The MA will document the informatin and it will be kept in the MAR Book so it can be easily found and checked. The RN and The Admin. will Check The book Monthly for ~~the~~ the next 3 months to Assure the information is documented.	10/30/22

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D 276	Continued From page 3 obtained from 08/01/22 through 08/09/22. -There was no documentation FSBS was obtained on 08/30/22 at 8:00am. Interview with the MA on 09/13/22 at 11:15am revealed she could not tell from looking at the FSBS Monitoring Log if she obtained the FSBS because she, the Administrator and the facility's Registered Nurse consultant were trying out different forms and she got confused when she was copying data from one form to the other. Interview with the Administrator on 09/13/22 at 4:52pm revealed she thought FSBS were being administered but they were not documented on the MAR because there was not enough room to document all the necessary information. 2. Review of Resident #2's current FL2 dated 02/21/22 revealed: -Diagnoses included hypertension. -There was an order for monthly blood pressures. Review of Resident #2's August 2022 medication administration record (MAR) revealed: -There was no entry for monthly blood pressure checks. -There was no monthly blood pressure documented. Review of Resident #2's September 2022 MAR revealed: -There was no entry for monthly blood pressure checks. -There was no monthly blood pressure documented. Interview with the medication aide (MA) on 09/13/22 at 10:30am revealed: -She had a binder on top of the medication cart	D 276	MA is now documenting The FSBS on the MAR. We are no longer using the other forms To document. This is to Prevent documentary Problems in the future The RA Consultant and the Adm will check behind the MA By weekly For 3 months to Assure The MA is documenting correctly	9/14/22

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D 276	Continued From page 4	D 276		

where she documented vital signs for residents.
-She checked Resident #2's blood pressure monthly but there was no documentation of Resident #2's blood pressures in her binder.

3. Review of Resident #1's current FL2 dated 02/10/22 revealed diagnoses included traumatic brain injury, seizures, schizoaffective disorder and hypercholesterolemia.

Review of Resident #1's record revealed there was an order dated 03/18/22 for FSBSs before meals, three times a week.

Review of Resident #1's August 2022 Fingerstick Blood Sugar (FSBS) Monitoring Log revealed:
-There was documentation FSBSs were ordered before meals on Monday, Wednesday and Friday.
-There was no documentation of FSBSs before any meals on Friday 08/19/22.
-There was no documentation of FSBSs before any meals on Monday 08/22/22.
-There was no documentation of a FSBS before dinner on Wednesday 08/24/22.

Review of Resident #1's September 2022 FSBS Monitoring Log revealed:
-There was documentation FSBSs were ordered before meals on Monday, Wednesday and Friday.
-There was no documentation of a FSBS before dinner on Wednesday 09/07/22.
-There was no documentation of a FSBS before dinner on Friday 09/09/22.
-There was no documentation of a FSBS before lunch or dinner on Monday 09/12/22.

Interview with the MA on 09/13/22 at 11:15am revealed:

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D 276	Continued From page 5 -Some FSBSs may not have been documented because Resident #1 refused FSBSs sometimes. -She did not document refusals on the FSBS Monitoring Log or on the MAR because it never occurred to her to document a refused FSBS. -She thought she usually checked his FSBS before meals on Monday, Wednesday and Friday but she may have missed a few. -She could not tell from looking at the FSBS Monitoring Log if she administered the FSBS because she, the Administrator and the facility's Registered Nurse consultant were trying out different forms and she got confused when she was copying data from one form to the other. Interview with Resident #1 on 09/13/22 at 1:35pm revealed: -He had FSBSs before meals, three times a week. -He thought they were usually done. Interview with the Administrator on 09/13/22 at 4:52pm revealed she thought FSBS were being administered but they were not documented on the MAR because there was not enough room to document all the necessary information so a FSBS Monitoring log was used instead. Telephone interview with Resident #1's Primary Care Provider (PCP) on 09/14/22 at 11:52am revealed: -Resident #1 had orders for FSBSs before meals, three times a week because he had diabetes. -The MA should have requested the frequency of FSBSs be changed if Resident #1 was refusing them.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 6 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 4 sampled residents related to 3 medications to treat diabetes and one medication used to treat allergies (Resident #3), 2 medications used to treat diabetes (Resident #4), a medication used to treat a chronic cough (Resident #1), and a medication used to treat cough (Resident #2). The findings are: Review of the facility's undated Medication Administration Policy revealed: -Medications, prescription and non-prescription, will be administered in accordance with the prescribing practioner's orders. -Documentation will be provided by staff who administers medications to the residents on the facility medication administration record (MAR). -The MAR will include the resident's name, name of medication, strength and dosage or quantity of medication, instructions for administration, date and time of administration, name and initial of the person administering, omissions and refusals of medications, and for as needed medications the	D 358	To Assure Correct Administration and Documentation in future we are documenting All FSBS's on the MAR along with the Administration Order. To Assure in future New or Changed orders are Followed, The New orders will be processed by the MA. The MA will Fax The New orders to the Pharmacy the day they are Obtained. so the Changes can be made on the MAR. The MA Will Change the current MAR to Reflect the Changes. A copy will be Placed in Not box. When New MAR is received From Pharmacy the MA will Check to make sure Corrections were made. if not the	

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D 358	Continued From page 7 reason for use and results of use to the resident. -The MAR will be updated and changed when medication orders from the prescribing practitioner changes. 1. Review of Resident #3's current FL2 dated 07/07/22 revealed: -Diagnoses included diabetes mellitus type 2. -There was an order for fingerstick blood sugar (FSBS) checks before each meal and at bedtime. a. Review of Resident #3's record revealed an order dated 07/07/22 for Trulicity (used to treat diabetes) 3mg/0.5ml inject 0.5ml subcutaneously once weekly. Review of Resident #3's August 2022 medication administration record (MAR) revealed: -There was an entry for Trulicity 0.5ml inject subcutaneously to be administered on 08/02/22, 08/09/22, 08/16/22, 08/22/22 and 08/30/22. -There was documentation Trulicity 0.5ml was administered on 08/05/22, 08/16/22 and 08/30/22. -There was no documentation Trulicity 0.5ml was administered on 08/02/22 or 08/09/22. Observation of Resident #3's medications on hand revealed Trulicity was available for administration. b. There was an order dated 07/07/22 for Lantus (used to treat diabetes) 14 units subcutaneously at bedtime. Review of Resident #3's August 2022 medication administration record (MAR) revealed: -There was an entry for Lantus 14 units subcutaneously at bedtime. -A handwritten note, "see insulin record in insulin	D 358	MA will Make Corrections on the MAR and refax the pharmacy the Current orders. For the next 3 months 9/15 - 12/15/22 the RN Consultant and the Adm will Conduct every 2 weeks check of the MAR: Orders & documentation to Assure Administration and Documentation is Correct.	10/30/22

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D 358	Continued From page 8 room." -There was no documentation lantus was reduced to 7 units on 08/03/22. Review of Resident #3's August 2022 FSBS Monitoring Log revealed there were three different FSBS Monitoring logs for the month with 3 residents named with various dates and FSBS results. Interview with Resident #3 on 09/15/22 at 2:35pm revealed: -The endocrinologist wanted her to get her A1C up because it had been in the low 5's. -Every once in a while her blood sugar was low, but not in a long time. Interview with the certified medical assistant at Resident #3's endocrinologist on 09/16/22 at 10:25am revealed: -Resident #3's last appointment was 08/03/22. -At that appointment the Lantus was reduced to 7 units at bedtime. -Receiving the incorrect dose of insulin would be detrimental to the resident, resulting in either high or low blood sugars. Interview with the Medication Aide (MA) on 09/15/22 at 10:25am revealed: -The Administrator and the facility's contracted Registered Nurse (RN) each created an insulin documentation form. -She got confused when she tried to copy the FSBS numbers from one form to the new forms. Interview with the Administrator on 09/15/22 at 10:50am revealed if she knew the insulin was being administered incorrectly, she would have fixed it.	D 358	The Pharmacy printed and sent New Copies of the Physicians Orders For each resident we are having the Orders reviewed and Signed on each resident IF there are any discrepancies a note is attatched for the Physician to clarify the order. This is to prevent errors and Assure Accuracy in Administration and Documentation. The Nurse Consultant and the ADLs will Check the MAR, Cart and orders every 2 week. for Three months to Assure Accuracy. IF a problem is found it can be corrected as soon as possible	10/30/22 9/15-10/15/22

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c. There was an order dated 07/07/22 for humalog insulin (used to treat diabetes) sliding scale (SSI) before meals; less than 150= 0 units, 150-200=2 units, 201-250=4 units, 251-300= 6 units, 301-350= 8 units, 351-400=10 units, over 400= 10 units and call Primary Care Provider (PCP).

Review of Resident #3's August 2022 medication administration record (MAR) revealed:
-There was an entry for humalog SSI at meals.
-A handwritten note, "see insulin record in insulin room."

Review of Resident #3's August 2022 FSBS Monitoring Log revealed:
-There were three FSBS Monitoring logs for the month with 3 residents named with various dates and FSBS results.
-There was no documentation FSBSs were obtained from 08/01/22 through 08/09/22.
-FSBS was documented as 184 on 08/10/22 at 12:00pm and 0 units of insulin were administered but the correct amount should have been 2 units.
-FSBS was documented as 291 on 08/11/22 at 5:00pm and 0 units of insulin were administered but the correct amount should have been 6 units.
-FSBS was documented as 177 on 08/12/22 at 12:00pm and 0 units of insulin were administered but the correct amount should have been 2 units.
-FSBS was documented as 277 on 08/15/22 at 12:00pm and 4 units of insulin were administered but the correct amount should have been 6 units.
-FSBS was documented as 199 on 08/27/22 at 12:00pm and 1 unit of insulin was administered but the correct amount should have been 2 units.
-There was no documentation FSBS was obtained on 08/30/22 at 8:00am.

Review of Resident #3's FSBS Monitoring Log

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dated September 2022 revealed:
-FSBS was documented as 192 on 09/01/22 at 8:00am and 0 units of insulin were administered but the correct amount should have been 2 units.
-FSBS was documented as 188 on 09/02/22 at 12:00pm and 0 units of insulin were administered but the correct amount should have been 2 units.

Interview with the certified medical assistant at Resident #3's endocrinologist on 09/16/22 at 10:25am revealed:
-Resident #3's last appointment was 08/03/22.
-Receiving the incorrect dose of Humalog would be detrimental to the resident, resulting in either high or low blood sugars.

Interview with the Medication Aide (MA) on 09/15/22 at 10:25am revealed:
-The Administrator and the facility's contracted Registered Nurse (RN) each created an insulin documentation form.
-She got confused when she tried to copy the FSBS numbers from one form to the new forms.
-She did not know how the August insulin record got so messed up.

Interview with the Administrator on 09/15/22 at 10:50am revealed if she knew the insulin was being administered incorrectly, she would have fixed it.

d. There was an order dated 07/07/22 for humalog SSI insulin at bedtime; less than 200= 0 units,
201-250=2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 6 units, over 400= 6 units and call PCP.

Review of Resident #3's August 2022 medication administration record (MAR) revealed:

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D 358	Continued From page 11 -There was an entry for humalog SSI at bedtime. -A handwritten note, "see insulin record in insulin room." Review of Resident #3's July 2022 FSBS Monitoring Log revealed FSBS was documented as 162 on 07/15/22 at 9:00pm and 2 units of insulin were administered but the correct amount should have been 0 units. Review of Resident #3's August 2022 FSBS Monitoring Log revealed: -There were three FSBS Monitoring logs for the month with 3 residents named with various dates and FSBS results. -FSBS was documented as 162 on 08/05/22 at 9:00pm and 2 units of insulin were administered but the correct amount should have been 0 units. -FSBS was documented as 170 on 08/06/22 at 9:00pm and 2 units of insulin were administered but the correct amount should have been 0 units. -There was no documentation a FSBS was obtained on 08/08/22 at 9:00pm. -FSBS was documented as 163 on 08/09/22 at 9:00pm and 2 units of insulin were administered but the correct amount should have been 0 units. -FSBS was documented as 229 on 08/12/22 at 9:00pm and 4 units of insulin were administered but the correct amount should have been 2 units. -FSBS was documented as 152 on 08/13/22 at 9:00pm and 2 units of insulin were administered but the correct amount should have been 0 units. -FSBS was documented as 179 on 08/15/22 at 9:00pm and 2 units of insulin were administered but the correct amount should have been 0 units. -FSBS was documented as 185 at 08/17/22 at 9:00pm and 2 units of insulin were administered but the correct amount should have been 0 units. -FSBS was documented as 214 on 08/23/22 at 9:00pm and 4 units of insulin were administered	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 12 but the correct amount should have been 2 units. -FSBS was documented as 151 on 08/25/22 at 9:00pm and 2 units of insulin were administered but the correct amount should have been 0 units. -FSBS was documented as 159 on 08/26/22 at 9:00pm and 2 units of insulin were administered but the correct amount should have been 0 units. -FSBS was documented as 160 on 08/27/22 at 9:00pm and 2 units of insulin were administered but the correct amount should have been 0 units. Review of Resident #3's September 2022 FSBS Monitoring Log revealed: -FSBS was documented as 229 on 09/03/22 at 9:00pm and 0 units of insulin were administered but the correct amount should have been 2 units. -FSBS was documented as 159 on 09/05/22 at 9:00pm and 2 units of insulin were administered but the correct amount should have been 0 units. -FSBS was documented as 158 on 09/06/22 at 9:00pm and 2 units of insulin were administered but the correct amount should have been 0 units. -FSBS was documented as 238 on 09/07/22 at 9:00pm and 4 units of insulin were administered but the correct amount should have been 2 units. Interview with the Medication Aide (MA) on 09/15/22 at 10:25am revealed she thought the bedtime SSI was the same as the one before meals. Interview with Resident #3 on 09/15/22 at 2:35pm revealed: -Her endocrinologist wanted her to get her A1C up because it was in the low 5's. -Every once in a while her blood sugar got low but not in a long time. Interview with the certified medical assistant at Resident #3's endocrinologist on 09/16/22 at	D 358		

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	HAL011296	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

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D 358	Continued From page 13 10:25am revealed: -Resident #3's last appointment was 08/03/22. -The bedtime sliding scale insulin was discontinued at that appointment. -Receiving the incorrect dose of Humalog insulin would be detrimental to the resident, resulting in either high or low blood sugars. e. There was an order dated 07/07/22 for Zyrtec (used to treat allergies) 10mg at bedtime as needed for allergies. Review of Resident #3's July 2022 MAR revealed: -There was an entry for Zyrtec 10mg at bedtime as needed. -There was no documentation Zyrtec was administered from 07/08/22 through 07/31/22. Review of Resident #3's August 2022 MAR revealed: -There was an entry for Zyrtec 10mg at bedtime as needed. -There was no documentation Zyrtec was administered from 08/01/22 through 08/31/22. Review of Resident #3's September 2022 MAR revealed: -There was an entry for Zyrtec 10mg at bedtime as needed. -There was no documentation Zyrtec was administered from 09/01/22 through 09/12/22. Observation of Resident #3's medication on hand on 09/13/22 at 3:45pm revealed Zyrtec was not available to administer. Interview with Resident #3 on 09/15/22 at 2:35pm revealed: -It was ragweed season and she was allergic to ragweed.	D 358	Zyrtec refill was recieved 9/15/22. On 9/15/22 Resident was informed the Zyrtec was on hand if she needed it All she had todo was ask because it is not given rut in it is PRN. To Prevent this in the futur. The RN Consultant re-trained The MA's on Medicatn Administration includig PRN's and documentation. The RN Consultant will check PRN Administration Approx every 2 weeks when she does Chart reviews.	10/30/22 9/15/22 — 12/15/22 9/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 14 -She was kind of congested in her chest like when she got bronchitis. -She told the MA about the congestion last night but she did not know she needed to request Zyrtec because she thought she was getting it each day with her other medications. Interview with the pharmacy on 09/15/22 at 12:00pm revealed they had last dispensed 30 tablets on Zyrtec on 06/03/22. Interview with the Medication Aide (MA) on 09/15/22 at 10:25am revealed Resident #3 had not asked for any Zyrtec. 2. Review of Resident #4's current FL2 dated 08/09/21 revealed diagnoses included diabetes mellitus type 1. a. Review of Resident #4's physician's orders dated 08/09/21 revealed: -There was an order to check finger stick blood sugars (FSBS) four times daily at 7:30am, 11:30am, 4:30pm, and 8:00pm. -There was an order for aspart (a fast-acting insulin used to control high blood sugar levels) inject according to sliding scale before each meal. If the FSBS was 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, and greater than 400=call the primary care provider (PCP). -There was an order for aspart inject 6 units before breakfast at 8:00am. -There was an order for aspart inject 4 units before lunch at 11:30am. -There was an order for aspart inject 6 units before supper at 5:00pm. -There was an order for aspart inject 4 units before snacks as needed.	D 358		

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D 358	Continued From page 15 Review of Resident #4's physician's order dated 03/21/22 revealed: -There was an order for aspart inject 6 units before meals and at bedtime. -There was an order for aspart sliding scale insulin (SSI) at each meal with a reading of 151-200 give 1 unit, 201-250 give 2 units, 251-300 give 3 units, 301-350 give 4 units, and 351-400 give 5 units. Review of Resident #4's physician's order dated 07/08/22 revealed: -There was an order for aspart inject 6 units before meals and at bedtime. -There was an order for aspart SSI at each meal with a reading of 151-200 give 1 unit, 201-250 give 2 units, 251-300 give 3 units, 301-350 give 4 units, and 351-400 give 5 units. Review of Resident #4's July 2022 medication administration record (MAR) revealed: -There was a hand-written entry with aspart inject 6 units three times daily before meals with "documented in record in med room" hand-written on the MAR. -There was an entry for aspart inject 8 units three times daily before meals marked through with a single line and "see insulin record in insulin room" and "order correction" hand-written on the MAR. -There was an entry for aspart SSI at 8:00am, 12:00pm, and 5:00pm with no documentation aspart was administered from 07/01/22 through 07/31/22. Review of Resident #4's July 2022 FSBS Monitoring Log revealed: -There were 23 instances of the FSBS reading being 151 or greater between 07/20/22 through 07/31/22 with 10 doses aspart SSI documented as administered incorrectly.	D 358	To Assure there is no Confusion in the Future All FSBS is is documented on the MAR. including when Resident are not in Facility. New Physician Orders have been Obtained To Clarify any Confusion on qhs → RN Consultant has retrained the MA's on Medication Administration and Documentation. Including Insulin Administration and documentation. 10/24/22 RN & Adm will check every 2 weeks to Assure Accuracy. 10/30/22	

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D 358	Continued From page 16 -There were 6 instances between 07/20/22 through 07/31/22 at 8:00pm where aspart sliding scale insulin was administered when there was no order. -There 5 instances out of 29 opportunities aspart 6 units before meals was documented as administered incorrectly between 07/20/22 through 07/31/22. -There was no documentation aspart 6 units was administered before breakfast on 07/31/22. Review of Resident #4's August 2022 MAR revealed: -There was a hand-written entry with aspart inject 6 units three times daily before meals with "see insulin record in insulin room" hand-written on the MAR. -There was an entry for aspart SSI at 8:00am, 12:00pm, and 5:00pm with no documentation aspart was administered from 08/01/22 through 08/31/22. Review of Resident #4's August 2022 FSBS Monitoring Log revealed: -The monitoring log began on 08/12/22 and went through 08/31/22. -There were 30 instances of the FSBS reading being 151 or greater between 08/12/22 through 08/31/22 with 13 doses aspart SSI documented as administered incorrectly. -There was no documentation aspart 6 units was administered before lunch on 08/25/22, before supper on 08/29/22, and before supper on 08/30/22. Review of Resident #4's September 2022 MAR revealed: -There was an entry for aspart inject 8 units three times daily before meals with no documentation aspart was administered from 09/01/22 through	D 358		

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D 358	Continued From page 17 09/13/22. -There was an entry for aspart SSI at 8:00am, 12:00pm, and 5:00pm with no documentation aspart was administered from 09/01/22 through 09/13/22. Review of Resident #4's September 2022 FSBS Monitoring Log revealed: -The monitoring log began on 09/02/22 and went through 09/13/22. -There were 16 instances where the FSBS reading was greater than 151 with 5 doses of sliding scale insulin documented as administered incorrectly. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/15/22 at 12:00pm revealed: -Resident #4 had his medications dispensed from another pharmacy but they added the ordered medications to a MAR for the facility. -The last order faxed from the facility for Resident #4's aspart was received on 11/29/21 with a stop date of 11/29/22. -The facility was responsible for faxing new physician's orders to the pharmacy and the new MARs would be updated with the most current physician's orders. Interview with the facility's contracted Registered Nurse (RN) consultant on 09/13/22 at 11:34am revealed: -She completed a medication cart audit with the MA monthly. -She used the MAR to check for available medications for residents. -She did not audit MARs with physician orders in residents records. Interview with the medication aide (MA) on	D 358	Nurse Consultant has been instructed by Adm to check The MARs, Orders, and Cart to make sure in future if there are problems they are caught and Corrected As soon as Possible 9/23/22	

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D 358	Continued From page 18 09/14/22 at 8:30am revealed: -She was responsible for documenting the FSBS readings and amount of insulin administered to Resident #4 on the FSBS Monitoring Log since she did not use the MAR provided by the facility's contracted pharmacy because there was no designated place on the MAR to sign her initials. -Resident #4's family member took Resident #4 to his physician appointments so she did not know if she had a current order for Resident #4's insulin in the record. -Resident #4 would "tell" her if the PCP changed any medication orders. -Sometimes the PCP would send a copy of new medication orders with Resident #4 to give to her. -She did not know Resident #4 had physician's orders for aspart SSI to be administered at mealtimes dated 03/21/22 and 07/08/22 in Resident #4's record. -She was responsible for making sure new physician's orders were faxed to the pharmacy, updated on the MARs, clarifying orders, and administering the medications as ordered. -She "overlooked" the physician's orders for insulin changes on 03/21/22 and 07/08/22. Interview with the Administrator on 09/15/22 at 10:57am revealed: -The MA was responsible for making sure physician's orders were faxed to the pharmacy and the MARs were updated with the current medication orders. -She did not know why Resident #4's MARs had not been updated with the current insulin orders. -The facility's contracted pharmacy would then update the MARs when a new physician's order was faxed to them. -She did not know the MA had administered the incorrect amount of insulin to Resident #4 and never updated the record with the ordered dose.	D 358	To Assure in future That we seciver any new orders from the physicians when the family's take them To their appointments with the Physicians the MA will send a copy of the current MAR and a physicians Order sheet so the physician can review and make changes. When the resident returns to the facility The MA will ask For These papers to be returned. The MA will then send A copy To the Pharmacy and make Any necessary Changes to the MAR The Previously stated Procedure will be followed	10/30/22

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D 358	Continued From page 19 -The facility's contracted RN consultant was supposed to audit MARs when she completed a medication cart audit with the MA. Attempted interview with Resident #4 on 09/15/22 at 11:42am was unsuccessful due to being out of the facility. Attempted interview with Resident #4's PCP on 09/15/22 at 10:00am was unsuccessful. b. Review of Resident #4's physician's orders dated 08/09/21 revealed: -There was an order to check finger stick blood sugars (FSBS) four times daily at 7:30am, 11:30am, 4:30pm, and 8:00pm. -There was an order for glargine (a long-acting insulin used to control high blood sugar levels) inject 10 units every morning at 8:00am. -There was an order for glargine inject 24 units every evening at 8:00pm. Review of Resident #4's physician's order dated 03/21/22 revealed there was an order for glargine inject 15 units before breakfast and 15 units at bedtime. Review of Resident #4's physician's order dated 07/08/22 revealed there was an order for glargine inject 15 units before breakfast and 15 units at bedtime. Review of Resident #4's July 2022 medication administration record (MAR) revealed: -There was an entry for glargine 10 units every morning at 6:30am with no documentation glargine was administered. -There was an entry for glargine 24 units with supper at 4:45pm with no documentation glargine was administered.	D 358		

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D 358	Continued From page 20 -There was no entry for glargine 15 units before breakfast and 15 units at bedtime. Review of Resident #4's July 2022 FSBS Monitoring Log revealed: -There was no documentation glargine 15 units were administered before breakfast from 07/21/22 through 07/31/22. -Glargine 10 units was administered from 07/20/22 through 07/31/22 at 8:00am except on 07/21/22 and 07/31/22 with hand-written documentation "out". Review of Resident #4's August 2022 MAR revealed: -There was an entry for glargine 10 units every morning at 6:30am with no documentation glargine was administered. -There was an entry for glargine 24 units with supper at 4:45pm with no documentation glargine was administered. -There was no entry for glargine 15 units before breakfast and 15 units at bedtime. Review of Resident #4's August 2022 FSBS Monitoring Log revealed: -There was no documentation glargine 15 units before breakfast and 15 units at bedtime were administered from 08/01/22 through 08/11/22. -Glargine 10 units were documented as administered from 08/12/22 through 08/31/22 at 7:30am except on 08/13/22 with "church" hand-written. -There were 5 instances out of 20 opportunities glargine 15 units was documented as administered at 8:00pm. -Glargine 14 units were documented as administered on 08/12/22 and 08/24/22 at 8:00pm. -Glargine was not documented as administered	D 358		

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D 358	Continued From page 21 from 08/13/22 through 08/23/22, 08/26/22, and 08/31/22 at 8:00pm. Review of Resident #4's September 2022 MAR revealed: -There was an entry for glargine 10 units every morning at 6:30am. -There was no documentation glargine 10 units were administered at 6:30am from 09/01/22 through 09/13/22. -There was an entry for glargine 24 units with supper at 4:45pm. -There was no documentation glargine 24 units were administered at 4:45pm from 09/01/22 through 09/12/22. -There was no entry for glargine 15 units before breakfast and 15 units at bedtime. Review of Resident #4's September 2022 FSBS Monitoring Log revealed: -There was no documentation glargine 15 units before breakfast were administered from 09/01/22 through 09/13/22. -Glargine 10 units were documented as administered twice at 8:00am on 09/02/22. -Glargine 10 units were documented as administered daily at 8:00am from 09/04/22 through 09/13/22. -Glargine 15units were documented as administered twice on 09/02/22 at 8:00pm. -Glargine 15 units were documented as administered on 09/03/22 at 8:00pm when there was documentation Resident #4 was "out" of the facility. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/15/22 at 12:00pm revealed: -Resident #4's medications were dispensed from another pharmacy but they added the ordered	D 358		

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medications to a MAR for the facility.
-The last order faxed from the facility for Resident #4's glargine was received on 11/29/21 with a stop date of 11/29/22.
-Resident #4's physician's order for glargine was inject 10 units in the morning and 24 units with supper.
-The facility was responsible for faxing new physician's orders to the pharmacy and the new MARs would be updated with the most current physician's orders.

Interview with the facility's contracted Registered Nurse (RN) consultant on 09/13/22 at 11:34am revealed:
-She completed a medication cart audit with the MA monthly.
-She used the MAR to check for available medications for residents.
-She did not audit MARs with physician orders in residents records.

Interview with the medication aide (MA) on 09/14/22 at 8:30am revealed:
-She was responsible for documenting the FSBS readings and amount of insulin administered to Resident #4 on the FSBS Monitoring Log since she did not use the MAR provided by the facility's contracted pharmacy because the MAR did not have a designated place to sign her initials.
-Resident #4's family member took Resident #4 to his physician appointments so she did not know if she had a current order for Resident #4's insulin in the record.
-Resident #4 would "tell" her if the PCP changed any medication orders.
-Sometimes the PCP would send a copy of new medication orders with Resident #4 to give to her.
-She thought Resident #4 was supposed to be administered glargine 10 units every morning at

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8:00am.
-She administered glargine 10 units to Resident #4 every morning.
-She did not know Resident #4 had physician's orders for glargine 15 units at 8:00am dated 03/21/22 and 07/08/22 in Resident #4's record.
-She documented glargine 14 units were administered on 08/12/22 and 08/24/22 at 8:00pm to Resident #4 instead of 15 units by mistake.
-She was responsible for making sure new physician's orders were faxed to the pharmacy, updated on the MARs, clarifying orders, and administering the medications as ordered.
-She "overlooked" the physician's orders for insulin changes on 03/21/22 and 07/08/22.

Interview with the Administrator on 09/15/22 at 10:57am revealed:
-The MA was responsible for making sure physician's orders were faxed to the pharmacy and the MARs were updated with the current medication orders.
-She did not know why Resident #4's MARs had not been updated with the current insulin orders.
-The facility's contracted pharmacy would then update the MARs when a new physician's order was faxed to them.
-She did not know the MA had administered the incorrect amount of insulin to Resident #4 and never updated the record with the ordered dose.
-The facility's contracted RN consultant was supposed to audit MARs when she completed a medication cart audit with the MA.

Attempted interview with Resident #4 on 09/15/22 at 11:42am was unsuccessful due to being gone from the facility.

Attempted interview with Resident #4's PCP on

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D 358	Continued From page 24 09/15/22 at 10:00am was unsuccessful. 3. Review of Resident #2's current FL2 dated 02/21/22 revealed diagnoses emphysema and chronic obstructive pulmonary disease. Review of Resident #2's physician's standing order dated 02/21/22 revealed Robitussin (a medication used to treat cough) give 2 teaspoons (tsp) every 6 hours as needed for cough. Review of Resident #2's July 2022 medication administration record (MAR) revealed there was no entry for Robitussin give 2 tsp every 6 hours as needed for cough. Review of Resident #2's August 2022 MAR revealed there was no entry for Robitussin give 2 tsp every 6 hours as needed for cough. Review of Resident #2's September 2022 MAR revealed there was no entry for Robitussin give 2 tsp every 6 hours as needed for cough. Observation of Resident #2's medications on hand on 09/13/22 at 11:02am revealed there was no Robitussin available for administration. Interview with the medication aide (MA) on 09/13/22 at 11:30am revealed: -She did not have Robitussin available to administer to Resident #2 because she administered the remaining Robitussin a "couple days ago". -She was responsible for reordering medications from the pharmacy. -She had not reordered Robitussin from the facility's contracted pharmacy. -She and the facility's contracted registered nurse (RN) completed cart audits every 2 weeks and	D 358	MA has been instructed to re order Standing Order Medication when supplies are running Low and not wait until They run out. RN Consultant will check Standing order Supplies as she is doing Medication Cart audit. This will give one more person checking to Assure supplies are Available in future. She checks Chart Approx every 2 weeks 10/30/22 We now have Physicians Orders For Resident #2 to keep Cough Syrup at bed side. Resident has been instructed When he needs a new bottle of Cough Syrup he must Ask MA	

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D 358	Continued From page 25 would order medications when needed at that time. Interview with the facility's contracted RN consultant on 09/13/22 at 11:34am revealed: -She completed a medication cart audit with the MA monthly. -She used the MAR to check for available medications for residents. -She did not check the medication cart for medications ordered as standing orders. -She did not audit MARs with physician orders in residents records. Interview with Resident #2 on 09/13/22 at 11:40am revealed: -He always had a cough due to his emphysema and COPD. -He went to the PCP in July 2022 for his cough. -He coughed his "guts up" daily. -He went through approximately 5 bottles of cough syrup in August 2022. -He bought the cough syrup himself and kept it in his room because the facility did not have cough syrup to administer to him when he asked for it. Interview with the MA on 09/13/22 at 11:52am revealed: -She administered the last dose of Robitussin to Resident #2 on 09/13/22 around 8:30pm but she forgot to sign it on the MAR. -She did not administer Robitussin to Resident #2 "often". -She did not know Resident #2 was buying and self-administering Robitussin to himself. -She was responsible for writing on the MAR any medications used from the standing orders and documenting the medication as administered. -She did not add Robitussin to Resident #2's MAR and document when she administered it	D 358	MA has been instructed when Resident is given a bottle to order Then a new bottle from Pharmacy so we will have it on hand. To Prevent Future 9/15/22 Problems w/ #2's Cough Syrup Resident has been informed he can not purchase Cough syrup or Medications without letting the Staff know. He is aware he can now Keep Cough Syrup at bedside and he is to ask MA when he needs more Dr. Order for at bedside 10/1/22	

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D 358	Continued From page 26 because she "forgot". Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 09/13/22 at 12:02pm revealed: -The pharmacy supplied house stock medications for the facility which are administered for multiple residents with the order. -The pharmacy dispensed the house stock medications when they received a request from the facility due to the standing order medications were only administered as needed. -Robitussin 100mg/5ml was last requested by the facility and dispensed on 05/05/22. Interview with the Administrator on 09/13/22 at 5:21pm revealed: -The MA was responsible for requesting refills on medications to the pharmacy when a medication ran out. -The MA and the facility's contracted RN consultant were responsible for cart audits monthly to make sure medications were available for administration. Attempted interview with Resident #2's PCP on 09/13/22 at 10:42am was unsuccessful. 4. Review of Resident #1's current FL2 dated 02/10/22 revealed diagnoses included traumatic brain injury, seizures, schizoaffective disorder and hypercholesterolemia. Review of Resident #1's physician orders revealed: -There was an order dated 07/18/22 for Mucinex DM ER (extended release) 1,200-60mg (used to treat chronic cough) twice a day. -The order was written with refills for a 6-month supply.	D 358		

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D 358	Continued From page 27 Interview with Resident #1 on 09/13/22 at 1:25pm revealed: -He needed Mucinex every day because he always had respiratory issues. -He thought he received it with his other medications. Review of Resident #1's August 2022 MAR revealed: -There was an entry for Mucinex DM ER 1,200-60mg at 8:00am and 8:00pm. -Mucinex DM ER 1,200-60mg was documented as administered at 8:00am and 8:00pm from 08/01/22 through 08/31/22. Review of Resident #1's September 2022 MAR revealed: -There was an entry for Mucinex DM ER 1,200-60mg at 8:00am and 8:00pm. -Mucinex DM ER 1,200-60mg was documented as administered at 8:00am and 8:00pm from 09/01/22 through 09/12/22 and at 8:00am on 09/13/22. Observation of Resident #1's medications on hand on 09/13/22 at 11:15am revealed Mucinex DM ER 1,200-60mg tablets were unavailable for administration. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 09/13/22 at 2:22pm revealed: -A 6-month supply of Mucinex DM ER 1,200-60mg was ordered on 07/18/22 and 30 tablets were delivered to the facility on 07/18/22. -A refill was requested on 07/29/22 and 30 tablets were delivered the same day. -No other refills were requested. -Mucinex was usually ordered as a short term	D 358	New orders have been Obtained to Clarify Mucinex. ~~he~~ Resident #1 is now Receiving Medication 2 times per day routinely To Prevent future problem IF MA has questions she has been instructed to contact the physician For clarification. The RN will check this in her future Cart audit every week This way if problems are found they can be Fixed As soon As Possible	10/17/22 10/30/22

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D 358	Continued From page 28 medication and all refills needed to be requested rather than sent routinely with the monthly cart fill. Interview with a Medication Aide (MA) on 09/13/22 at 11:15am and 2:50pm revealed: -She thought Resident #1's Mucinex was currently an as needed medication because she did not think Mucinex was a long term medication. -She was not routinely administering it, even though she documented administration on the MAR. -When Resident #1's Mucinex was delivered on 07/18/22, a 2-week supply was received and it was administered twice a day. -When the refill with 30 more tablets was received on 07/29/22 she administered it as needed because his cough had improved. -She knew she was not allowed to decide if a resident needed a medication or not. Telephone interview with Resident #1's Primary Care Provider (PCP) on 09/14/22 at 11:52am revealed: -Mucinex was ordered because Resident #1 had a chronic productive cough due to smoking 1-2 packs of cigarettes for 20+ years. -Even though Mucinex was usually prescribed for short durations, she intended for Resident #1 to take it long term for his cough and chest congestion. -Not taking Mucinex would cause Resident #1 to continue to have a chronic cough. Interview with the Administrator on 09/13/22 at 4:52pm revealed: -The MA knew how to read the MAR and administer medications accurately. -She did not know Resident #1 was not routinely being administered Mucinex.	D 358		

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D 358	Continued From page 29 The facility failed to administer medications as ordered for Resident #3 related to non-insulin medication, and short and long acting insulins and an allergy medication, and for Resident #4 related to short and long acting insulin and for Resident #1 and #2 related to cough medication, resulting in Resident #3 not receiving at least 2 doses of a non-insulin medication prescribed weekly, and Resident #3 and Resident #4 receiving incorrect dosages of short and long acting insulins, and Resident #1 and #2 not receiving cough medications. This failure was detrimental to the health of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2022.	D 358	Nurse Consultant has Retrained the MA's On Medication Administration And documentation. To include Insulin and and non insulin Medications. Both the RN and the Adm will check Behind the MA's every 2 weeks for 3 months to Assure medication Administration And documentation are Correct.	9/22/22 10/30/22 9/15-12/15/22
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	D 367	To Clarify and Prevent Future Problems New Physician's orders have been obtained and Copies Sent to the pharmacy to Assure MARs are Correct The MA will correct Mars to reflect New Orders	

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D 367	Continued From page 30 documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure the medication administration records (MARs) were accurate for 4 of 4 sampled residents (#1, #2, #3, and #4) related to medications to treat chest congestion, heartburn, elevated cholesterol levels, athletes foot and fingerstick blood sugar (FSBS) readings (Resident #1), two medications used to treat high blood sugar levels (#4), a medication used to treat cough (#2), and 3 medications to treat diabetes (Resident #3) The findings are: 1. Review of Resident #3's current FL2 dated 07/07/22 revealed diagnoses included diabetes mellitus Type 2. a. Review of Resident #3's current FL2 dated 07/07/22 revealed there was an order for Lantus 14 units subcutaneously at bedtime (used to treat diabetes mellitus). Review of Resident #3's record revealed a subsequent order dated 08/03/22 for Lantus to be reduced to 7 units at bedtime. Review of Resident #3's August 2022 MAR	D 367	The day they are received The MA will check the new MARS to Make sure Corrections were made by the Pharmacy. If not Made The MA will refax Orders to The pharmacy Both RN and Adm will be checking every 2 weeks for 3 months 9/15/22-12/15/22 to ensure Medication is being Administered and documented Correctly As Related in the 9/15/22 Plan of Protection All FSBS is now being documented on MAR To eliminate confusion We are no longer using the other forms to document.	10/30/22

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D 367	Continued From page 31 revealed: -A entry for Lantus 14 units subcutaneously at bedtime. -There was no entry for Lantus 7 units at bedtime. -There was no documentation Lantus was administered from 08/01/22 through 08/31/22. Refer to interview with the Administrator on 09/13/22 at 4:52pm. b. Review of Resident #3's current FL2 dated 07/07/22 revealed there was an order for Humalog insulin (used to treat diabetes mellitus) per sliding scale (SSI) before meals: Less than 150= 0 units, 150-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, Over 400= 10 units and call MD. Review of Resident #3's August 2022 MAR revealed: -An entry for Humalog insulin per sliding scale (SSI) before meals: less than 150= 0 units, 150-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, Over 400= 10 units and call MD. -There was no documentation Humalog was administered from 08/01/22 through 08/31/22. Interview with the Medication Aide (MA) on 09/15/22 at 10:25am revealed she did not document on the MAR because she thought there was not enough room to document all the information. Refer to interview with the Administrator on 09/13/22 at 4:52pm. c. Review of Resident #3's current FL2 dated 07/07/22 revealed there was an order for	D 367		

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D 367	Continued From page 32 Humalog insulin (used to treat diabetes mellitus) per sliding scale (SSI) at bedtime: Less than 200= 0 units, 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 6 units, Over 400= 6 units and call MD. Review of Resident #3's August 2022 MAR revealed: -An entry for Humalog insulin per sliding scale at bedtime: less than 200= 0 units, 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 6 units, Over 400= -There was no documentation Humalog was administered from 08/01/22 through 08/31/22. Review of Resident #3's August 2022 insulin record revealed there was a duplicate entry documented on 08/31/22. Interview with Medication Aide (MA) on 09/13/22 at 11:35am and 09/15/22 at 8:30am revealed she was responsible for documenting the FSBS readings and amount of insulin administered on the FSBS Monitoring Log since she did not use the MAR provided by the facility's contracted pharmacy. Refer to interview with the Administrator on 09/13/22 at 4:52pm. 2. Review of Resident #4's current FL2 dated 08/09/21 revealed diagnoses included diabetes type 1 and bipolar disorder. Review of Resident #4's physician's health summary dated 03/03/22 revealed Resident #4 had fingerstick blood sugars (FSBS) to be checked four times daily with meals and at bedtime.	D 367		

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D 367	Continued From page 33 a. Review of Resident #4's physician's order dated 07/08/22 revealed: -There was an order for aspart (a quick acting insulin to treat high blood sugar levels) inject 6 units before meals and at bedtime. -There was an order for aspart sliding scale insulin (SSI) at each meal with a reading of 151-200 give 1 unit, 201-250 give 2 units, 251-300 give 3 units, 301-350 give 4 units, and 351-400 give 5 units. Review of Resident #4's July 2022 medication administration record (MAR) revealed: -There was a hand-written entry with aspart inject 6 units three times daily before meals with "documented in record in med room" hand-written on the MAR. -There was no entry for aspart inject 6 units at bedtime. -There was an entry for aspart inject 8 units three times daily before meals marked through with a single line and "see insulin record in insulin room" and "order correction" hand-written on the MAR. -There was an entry for aspart SSI at 8:00am, 12:00pm, and 5:00pm. Review of Resident #4's August 2022 MAR revealed: -There was a hand-written entry with aspart inject 6 units three times daily at 7:30am, 11:30am, and 4:30pm with "see insulin record in insulin room" hand-written on the MAR. -There was no entry for aspart inject 6 units at bedtime. -There was an entry for aspart SSI at 8:00am, 12:00pm, and 5:00pm. Review of Resident #4's September 2022 MAR revealed: -There was an entry for aspart inject 8 units three	D 367		

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times daily at 7:30am, 11:30am, and 4:30pm.
-There was no entry for aspart inject 6 units before meals and at bedtime.
-There was an entry for aspart SSI at 8:00am, 12:00pm, and 5:00pm.

Interview with the medication aide (MA) on 09/14/22 at 8:30am revealed she was responsible for documenting the FSBS readings and amount of insulin administered to Resident #4 on the FSBS Monitoring Log since she did not use the MAR provided by the facility's contracted pharmacy because there was not enough room to document.

Interview with the Administrator on 09/15/22 at 10:57am revealed:
-The MA was responsible for making sure physician's orders were faxed to the pharmacy and the MARs were updated with the current medication orders.
-She did not know why Resident #4's MARs had not been updated with the current insulin orders.
-The facility's contracted pharmacy would then update the MARs when a new physician's order was faxed to them.
-She did not know the MA did not updated the record with the newly ordered dose.
-She expected the MA to follow the facility's policy and procedures for medication administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/15/22 at 12:00pm revealed:
-Resident #4 had his medications dispensed from another pharmacy but they added the ordered medications to a MAR for the facility when the facility faxed the new order.
-The last order faxed from the facility for Resident #4's aspart was received on 11/29/21 with a stop

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D 367	Continued From page 35 date of 11/29/22. -The facility was responsible for faxing new physician's orders to the pharmacy and the new MARs would be updated with the most current physician's orders. Refer to interview with the Administrator on 09/13/22 at 4:52pm. b. Review of Resident #4's physician's order dated 07/08/22 revealed there was an order for glargine inject 15 units before breakfast and 15 units at bedtime. Review of Resident #4's July 2022 medication administration record (MAR) revealed: -There was an entry for glargine 10 units every morning at 6:30am. -There was an entry for glargine 24 units with supper at 4:45pm. -There was no entry for glargine inject 15 units before breakfast and 15 units at bedtime. Review of Resident #4's August 2022 MAR revealed: -There was an entry for glargine 10 units every morning at 6:30am. -There was an entry for glargine 24 units with supper at 4:45pm. -There was no entry for glargine inject 15 units before breakfast and 15 units at bedtime. Review of Resident #4's August 2022 FSBS Monitoring Log revealed: -The monitoring log began on 08/12/22 and went through 08/31/22. -Glargine 10 units, not 15 units, were documented as administered from 08/12/22 through 08/31/22 at 7:30am. -There were 5 instances out of 20 opportunities	D 367	All insulin Records have been updated and reviewed by Physician.	10/20/22

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D 367	Continued From page 36 glargine 15 units was documented as administered at 8:00pm. Review of Resident #4's September 2022 MAR revealed: -There was an entry for glargine 10 units every morning at 6:30am. -There was an entry for glargine 24 units with supper at 4:45pm. -There was no entry for glargine inject 15 units before breakfast and 15 units at bedtime. Review of Resident #4's September 2022 FSBS Monitoring Log revealed: -Glargine 10 units were documented as administered twice at 8:00am on 09/02/22. -Glargine 10 units, not 15 units, were documented as administered daily at 8:00am from 09/04/22 through 09/13/22. -Glargine 15units were documented as administered twice on 09/02/22 at 8:00pm. -Glargine 15 units were documented as administered on 09/03/22 at 8:00pm when there was documentation Resident #4 was "out" of the facility. Interview with the medication aide (MA) on 09/14/22 at 8:30am revealed: -She found a piece of paper in a stack of papers on 09/13/22 around 11:00pm that she wrote Resident #4's FSBS readings with the documented amount of insulin she had administered for 08/01/22 through 08/11/22. -She did not want to make the paper available for review because the FSBS readings and insulin documentation were "mixed up" and she was embarrassed. -She was responsible for documenting the FSBS readings and amount of insulin administered to Resident #4 on the FSBS Monitoring Log since	D 367		

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	HAL011296	A. BUILDING: _____ B. WING _____	09/15/2022

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she did not use the MAR provided by the facility's contracted pharmacy.
-Resident #4's family member took Resident #4 to his physician's appointments, so she did not know if she had a current order for Resident #4's MAR.
-She did not know Resident #4 had physician's orders for glargine 15 units at 8:00am dated 03/21/22 and 07/08/22 in Resident #4's record.
-She was responsible for making sure new physician's orders were faxed to the pharmacy, updated on the MARs, clarifying orders.
-She did not update the MAR because she "overlooked" the physician's orders for insulin changes on 03/21/22 and 07/08/22.

Telephone interview with an assistant from Resident #4's PCP on 09/15/22 at 9:15am revealed:
-The current insulin orders for Resident #4 were dated 07/08/22.
-There was an order for glargine inject 15 units before breakfast and 15 units at bedtime.

Interview with the Administrator on 09/15/22 at 10:57am revealed:
-The MA was responsible for making sure physician's orders were faxed to the pharmacy and the MARs were updated with the current medication orders.
-She did not know why Resident #4's MARs had not been updated with the current insulin orders.
-The facility's contracted pharmacy would then update the MARs when a new physician's order was faxed to them.
-She did not know the MA had not updated the record with the ordered dose.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/15/22 at

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D 367	Continued From page 38 12:00pm revealed: -Resident #4 had his medications dispensed from another pharmacy but they added the ordered medications to a MAR for the facility when the facility faxed the new order. -The last order faxed from the facility for Resident #4's glargine was received on 11/29/21 with a stop date of 11/29/22. -Resident #4's physician's order for glargine was inject 10 units in the morning and 24 units with supper. -The facility was responsible for faxing new physician's orders to the pharmacy and the new MARs would be updated with the most current physician's orders. Refer to interview with the Administrator on 09/13/22 at 4:52pm. 3. Review of Resident #2's current FL2 dated 02/21/22 revealed diagnoses emphysema and chronic obstructive pulmonary disease. Review of Resident #2's physician's standing order dated 02/21/22 revealed there was an order for Robitussin (a medication used to treat cough) give 2 teaspoons (tsp) every 6 hours as needed for cough. Review of Resident #2's July 2022 medication administration record (MAR) revealed there was no entry for Robitussin give 2 tsp every 6 hours as needed for cough. Review of Resident #2's August 2022 MAR revealed there was no entry for Robitussin give 2 tsp every 6 hours as needed for cough. Review of Resident #2's September 2022 MAR revealed there was no entry for Robitussin give 2	D 367	As explained on pg. 25 and 26. 10/20/22	

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D 367	Continued From page 39 tsp every 6 hours as needed for cough. Interview with the MA on 09/13/22 at 11:52am revealed: -She was responsible for documenting on the MAR any medications used from the standing orders and documenting the medication as administered. -She did not add Robitussin to Resident #2's MAR and document when she administered it. Refer to interview with the Administrator on 09/13/22 at 4:52pm. 4. Review of Resident #1's current FL2 dated 02/10/22 revealed diagnoses included traumatic brain injury, seizures, schizoaffective disorder and hypercholesterolemia. a. Review of Resident #1's physician order summary dated 05/17/22 revealed there was an order for Tinactin 1% aerosol powder (used to treat athlete's foot) to be applied daily. Review of Resident #1's August 2022 MAR revealed: -There was an entry for Tinactin 1% aerosol powder to be applied daily. -There was documentation Tinactin 1% aerosol powder was administered daily from 08/01/22 through 08/31/22. Interview with a Medication Aide (MA) on 09/13/22 at 11:15am revealed: -Resident #1's Tinactin Spray was only to be administered when he had athlete's foot. -She had not administered the Tinactin spray in several months because he was not having a problem with athlete's foot. -She documented she administered it in August	D 367	Resident #1 Tinactin 1% Aerosol Powder was DC'ed 10/17/22 because Condition is Cleared	10/17/22

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D 367	Continued From page 40 2022 but that was a mistake. Observation of Medications on hand revealed a nearly full can of Tinactin 1% aerosol powder was available for administration. Interview with Resident #1 on 09/13/22 at 1:25pm revealed he did not currently have any athlete's foot and had not used the Tinactin 1% powder in about 6 months. Refer to interview with the Administrator on 09/13/22 at 4:52pm. b. Review of Resident #1's physician orders revealed there was an order dated 07/18/22 for Mucinex DM ER 1,200-60mg (used to treat chronic cough) twice a day. Review of Resident #1's August 2022 MAR revealed: -There was an entry for Mucinex DM ER 1,200-60mg at 8:00am and 8:00pm. -Mucinex DM ER 1,200-60mg was documented as administered at 8:00am and 8:00pm from 08/01/22 through 08/31/22. Review of Resident #1's September 2022 MAR revealed: -There was an entry for Mucinex DM ER 1,200-60mg at 8:00am and 8:00pm. -Mucinex DM ER 1,200-60mg was documented as administered at 8:00am and 8:00pm from 09/01/22 through 09/12/22 and at 8:00am on 09/13/22. Observation of Resident #1's medications on hand on 09/13/22 at 11:15am revealed Mucinex was unavailable for administration.	D 367		

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D 367	Continued From page 41 Interview with a Medication Aide (MA) on 09/13/22 at 11:15am and 2:50pm revealed: -Resident #1's Mucinex was currently an as needed medication. -She was so used to documenting administration on the MAR that she accidentally continued to sign for it even though there was no mucinex available to administer. Refer to interview with the Administrator on 09/13/22 at 4:52pm. c. Review of Resident #1's record revealed there was an order dated 03/18/22 for FSBS at meals three times a week. Review of Resident #1's September 2022 Fingerstick Blood Sugar (FSBS) Monitoring Log revealed: -There was no documentation of any FSBSs on 09/02/22. -There was no documentation of a FSBS reading on 09/05/22 at dinner. -There was documentation of a FSBS reading of 89 on 09/07/22 at breakfast. Review of Resident #1's glucometer revealed: -There were FSBSs of 93, 35 and 144 on 09/02/22. -There were FSBSs of 207, 165 and 192 on 09/03/22. -There was a FSBS of 106 on 09/07/22. Interview with the MA on 09/13/22 at 11:15am revealed: -Some FSBSs may not have been documented because she either forgot to document the FSBS or Resident #1 refused a FSBS. -She did not document refusals on the FSBS Monitoring Log or on the MAR because it never	D 367	Resident #1 FSBS's and All Other Medication Orders - have been review by Provider and up dated. FSBS's are now Order 2 time a day 3 days a week Nurse Consultant has retrained MA's on Medication Administration and documentation as directed on Page. No. all documentation of FSBS's is now on MAR To eliminate Confusion in the future	10/17/22 9/26/22 9/15/22

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D 367	Continued From page 42 occurred to her to document a refused FSBS. -The FSBS Monitoring Log was a mess because she, the Administrator and the facility's contracted Registered Nurse were trying out different forms and she got confused when she was copying data from one form to the other. Interview with the Administrator on 09/13/22 at 4:52pm revealed FSBSs were not documented on the MAR because there was not enough room to document all the necessary information. Refer to interview with the Administrator on 09/13/22 at 4:52pm. Interview with the Administrator on 09/13/22 at 4:52pm revealed she thought the MAR accuracy problems were fixed after the last survey because new forms were developed and she monitored the MARs.	D 367		
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 observation, interview and record review the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and regulations as related to Medication Administration and Infection Prevention.	D912		

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D912	Continued From page 43 The findings are: Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 4 sampled residents related to 3 medications to treat diabetes and one medication used to treat allergies (Resident #3), 2 medications used to treat diabetes (Resident #4), a medication used to treat a chronic cough (Resident #1), and a medication used to treat cough (Resident #2). [Refer to Tag 358, 10A NCAC 13F, 1004(a), Medication Administration (Type B Violation)]. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 2 of 3 sampled diabetic residents (#3 and #4) with orders for blood sugar monitoring resulting in shared glucometers. [Refer to Tag 932 GS 131D 4.4A, Adult Care Home Infection Prevention Requirements (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 (b) In order to prevent transmission of infectious diseases, each adult care home shall do all of the following: (1) Implement written infection prevention and control policies and procedures that are based on	D932		

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D932	Continued From page 44 accepted national standards consistent with the federal Centers for Disease Control and Prevention guidelines on infection control, which shall be maintained in the facility and accessible to adult care home staff working at the facility. The policies and procedures shall address 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 resident 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. g. Standard and transmission-based precautions, including the following: 1. Respiratory hygiene and cough etiquette.	D932		

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D932	Continued From page 45 2. Environmental cleaning and disinfection. 3. Reprocessing and disinfection of reusable resident devices. 4. Hand hygiene. 5. Accessibility and proper use of personal protective equipment. 6. Types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions. h. In accordance with the public health laws of North Carolina, when and how to report to the local health department a suspected or confirmed, reportable communicable disease case or condition, or a communicable disease outbreak. i. Procedures for ensuring that residents, representatives of residents, and adult care home staff are informed of the following without disclosing any personally identifiable information of the facility's residents or staff: 1. The existence of a communicable disease outbreak within 24 hours following confirmation of the outbreak by the local health department. 2. When the communicable disease outbreak has resolved. 3. Any changes to facility operations during the communicable disease outbreak, such as visitation policy changes. j. Measures the facility should consider for specific types of communicable disease outbreaks in order to prevent the spread of	D932		

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D932	Continued From page 46	D932		

illness, such as:
1. Isolating infected residents.
2. Limiting or stopping group activities and communal dining.
3. Limiting or restricting outside visitation to the facility.
4. Screening staff, residents, and visitors for signs of illness.
5. Using source control as tolerated by the residents.
k. Strategies for addressing potential staffing issues and ensuring
adequate staffing is available to meet the needs of the residents during
a communicable disease outbreak.
(2) Require and monitor compliance with the facility's infection prevention and
control policies and procedures.
(3) Update the infection prevention and control policies and procedures as
necessary to maintain consistency with accepted national standards in infection prevention and control.
(4) Designate one on-site staff member for each noncontiguous facility who is
knowledgeable about the federal Centers for Disease Control and Prevention
guidelines on infection control to direct the facility's infection control
activities and ensure that all adult care home staff is trained in the facility's
written infection prevention and control policies and procedures
developed pursuant to subdivision (b)(1) of this section within 30 days after
hire and annually thereafter. Any nonsupervisory staff member designated to
direct the facility's infection control activities shall complete the infection

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D932	Continued From page 47 control course developed by the Department pursuant to G.S. 131D-4.5C. (5) When a communicable disease outbreak has been identified at a facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's infection control and prevention policies and procedures developed pursuant to subdivision (b)(1) of this section and related policies and procedures; section; provided, however, that if guidance or directives specific to a communicable disease outbreak or emerging infectious disease threat have been issued in writing by the Department or local health department, the Department's or local health department's specific guidance or directives shall be implemented by the facility. Effective January 1, 2022 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 2 of 3 sampled diabetic residents (#3 and #4) with orders for blood sugar monitoring resulting in shared glucometers. The findings are:	D932		

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Review of the CDC guidelines for infection control revealed:
-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 instructions.
-If the manufacturer does not list disinfection information, the glucometer should not be shared between residents.

Review of the cleaning and disinfection instructions for the Brand A glucometer revealed the glucometer was intended to be used by a single person and should not be shared.

Review of the facility's undated Infection Control Policy did not contain information regarding procedure for checking fingerstick blood sugars (FSBS) or the use of glucometers.

1. Review of Resident #4's current FL2 dated 08/09/21 revealed diagnoses included diabetes mellitus type 1.

Review of Resident #4's physician's orders dated 08/09/21 revealed:
-There was an order to check FSBS four times daily at 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was an order for basaglar (a long-acting insulin used to control high blood sugar levels) inject 10 units every morning at 8:00am.
-There was an order for basaglar inject 24 units every evening at 8:00pm.
-There was an order for aspart (a fast-acting insulin used to control high blood sugar levels) inject according to sliding scale before each meal. If FSBS was 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, and greater than 400=call the

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	HAL011296	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

(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 49 primary care provider (PCP). -There was an order for aspart inject 6 units before breakfast at 8:00am. -There was an order for aspart inject 4 units before lunch at 11:30am. -There was an order for aspart inject 6 units before supper at 5:00pm. -There was an order for aspart inject 4 units before snacks as needed. Observation of Resident #4's Brand A glucometer on 09/13/22 at 5:35pm revealed: -The glucometer was not labeled with Resident #4's name but was stored inside a clear box labeled with Resident #4's name. -There was no date or time when the glucometer was turned on but appeared to register approximately 3 hours early on time when compared to the documented FSBS's. -The glucometers history began on 07/20/22 at 4:57am and ended on 09/13/22 at 8:52am. Review of Resident #4's glucometer history compared to the August 2022 MAR revealed there was a FSBS value of 109 on 08/26/22 at 6:22pm recorded on Resident #4's glucometer that corresponded to a FSBS documented on another resident's MAR and was missing from the other resident's glucometer. Review of Resident #4's glucometer history compared to the September 2022 MARs revealed there was a FSBS value of 373 documented on Resident #4's MAR on 09/12/22 4:30pm that was missing from Resident #4's glucometer and corresponded to a FSBS value recorded on another resident's glucometer. Interview with the medication aide (MA) on 09/13/22 at 5:27pm revealed:	D932	When it was realized on 9/15/22 a mistake had been made with resident #3 glucometer a new glucometer was Purchased that day. Resident #3 has new glucometer all glucometers are now labeled with the resident name. also the Strips boxes they are kept in separately are clearly labeled with the resident Name. to prevent confusion in future also MA will only have 1 resident out at a time at insulin closet for testing. Administrator went over Infection control with emphasis on diabetic testing and equipt cleaning. 9/15/22 Administrator observed testing week of 9/28/22	

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	HAL011296	A. BUILDING: _____ B. WING _____	09/15/2022

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WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

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D932	Continued From page 50 -She was responsible for checking all residents FSBS. -She never used one resident's glucometer to check another resident's FSBS. -She did not know how Resident #4's FSBS was recorded on another resident's glucometer. Interview with the Administrator on 09/15/22 at 9:05am revealed: -The facility's Infection Control Policy included each glucometer was designated for a single person with FSBS orders. -She did not know the MA used Resident #4's glucometer to check another resident's FSBS. Attempted interview with Resident #4 on 09/15/22 at 11:42am was unsuccessful because he was out of the facility. 2. Review of Resident #3's current FL2 dated 07/07/22 revealed: -Diagnoses included diabetes mellitus Type 2. -There was an order for Humalog insulin per sliding scale (SSI) before meals: Less than 150= 0 units, 150-20= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, Over 400= 10 units and call the Primary Care Provider (PCP). -There was an order for Humalog insulin per sliding scale at bedtime. Less than 200= 0 units, 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 6 units, Over 400= 6 units and call MD. Observation of Resident #3's Brand B glucometer on 09/15/22 at 10:30am revealed the glucometer was in a case that was labeled with Resident #3's name but the glucometer was not labeled. Review of Resident #3's glucometer history	D932	10/3/22 and 10/10/22 RN Consultant had Infection Control Class with MA's. with emphasis on Insulin testing and equipment use and cleaning.	9/24/22 9/30/22

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D932	Continued From page 51	D932		

compared to the MARs for September 2022 revealed:
-The date and time were correct when the glucometer was turned on.
-The glucometer's history began on 06/05/22 at 8:18am and ended on 09/13/22 at 9:22pm.
-There were two FSBS values on Resident #3's glucometer on 09/12/22 which were 5 minutes apart; one at at 6:30pm with FSBS of 97 and one at 6:35pm with FSBS of 373.

Review of Resident #3's insulin record for September 2022 revealed a FSBS of 97 on 09/12/22 at 6:30pm but the FSBS of 373 at 6:35pm was documented on another resident record .

Interview with the medication aide (MA) on 09/13/22 at 5:27pm revealed:
-She was responsible for checking all residents FSBS.
-She never used one resident's glucometer to check another resident's FSBS.
-She did not know how another resident's FSBS was recorded on Resident #3's glucometer.

Interview with the Administrator on 09/15/22 at 9:05am revealed:
-The facility's Infection Control Policy included each glucometer was designated for a single person with FSBS orders.
-She did not know the MA had used another resident's glucometer to check Resident #3's FSBS.

The facility failed to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines for finger stick blood sugar checks. The facility's failure placed the residents at risk to possible exposure and

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D932	Continued From page 52 transmission of blood borne pathogens by sharing of glucometers between Residents #3 and #4. This failure was detrimental to the health and safety of the residents receiving finger stick blood sugar checks and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2022.	D932		