STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-092270	A. BUILDING: _____ B. WING _____	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESERVE AT MILLS FARM VILLA #3	2020 MILLS CHASE LOOP APEX, NC 27523

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 11/17/22.	C 000	The measures that have been put into place to correct this violation is: a) Medication Technician training regarding Medication administration was started on 11/18/22 and will be completed by 11/21/22 by DCS/Designee. b) Going forward, orders will be administered according to written physician orders. c) Medication Technician training on infection control measures when administering medications was begun on 11/18/22 and will be completed by 11/21/22 by DCS/Designee.	
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record review and interviews, the facility failed to ensure a medication was administered as ordered for 1 of 3 sampled residents (#1) with an order for scheduled insulin. The findings: Review of Resident #1's FL-2 dated 09/01/22 revealed: -Diagnoses included type 2 Diabetes, dementia, and hypertension. -He was intermittently disoriented. -He had wandering behaviors. -He was difficult to understand. Review of Resident #1's signed physician orders dated 09/01/22 revealed Aspart insulin Flex pen 100unit/ml inject 2 units three times per day (TID);	C 330		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Germain RN, ED — TITLE — (X6) DATE: 12/29/22

STATE FORM 6899 ZKFL11 If continuation sheet 1 of 6

Reviewed and Acknowledged 01/11/23 Melissa A. Floyd

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C 330	Continued From page 1	C 330		

before meals; do not give if fasting blood sugar (FSBS) level was less than 100. (Aspart insulin was a short-acting insulin. Novolog was the brand name version of Aspart. Novolog was used to treat people with type 2 diabetes who needed insulin to control their diabetes).

Review of Resident #1's signed physician's communication dated 10/11/22 revealed:
-The facility requested a sliding scale for insulin due to blood sugar levels being high.
-The Primary Care Provider (PCP) increased Aspart insulin to 5 units TID before meals.
-There were no FSBS readings ordered.

Observation of Resident #1 sitting at a dining table for breakfast on 11/17/22 at 8:12am revealed:
-The Medication Aide (MA) took his FSBS and documented the reading as 76.
-The MA told him; he did not need his insulin because his blood sugar level was good.

Observation of Resident #1 sitting at the activity table before lunch on 11/17/22 at 11:29am revealed:
-The MA took his FSBS and documented the reading as 200.
-The MA told him she needed to give him insulin.
-The MA administered the insulin.

Review of Resident #1's September 2022 electronic medical administration record (eMAR) revealed:
-There was an entry for Novolog injection Flex pen 2 units TID before meals at 7:30am, 11:30am and 4:3pm.
-There was an entry to check FSBS and do not administer Novolog if FSBS was less than 100.

d) Medication Technician training on the 8 rights of Medication administration was begun on 11/18/22 and will be completed by 11/21/22 by the DCS/ Designee.

e) Medication Technician training on how to process orders correctly for medication administration ensuring they are correctly placed on the eMAR was begun on 11/18/22 and will be completed on 11/21/22 by the DCS/ Designee.

2) A chart to EMAR audit was completed on 11/21/22 by DCS/RCC assuring accuracy of medication orders.

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C 330	Continued From page 2	C 330		

Review of Resident #1's October 2022 eMAR revealed:
-There was an entry for Novolog injection Flex pen 2 units TID before meals at 7:30am, 11:30am and 4:30pm.
-There was an entry to check FSBS and do not administer Novolog if FSBS was less than 100.
-The entry for Novolog injection Flex pen 2 units TID before meals with parameters was discontinued on the eMAR dated 10/11/22.
-There was an entry to inject 5 units of Novolog Flex pen subcutaneously before meals at 7:30am, 11:30am and 4:30pm dated 10/12/22.
-Insulin was not administered on 10/17/22 at 7:30am, 10/19/22 at 7:30am, 10/21/22 at 11:30am, and 10/26/22 at 7:30am due to FSBS that was below 100.
-There was no entry to check FSBS, after 10/11/22.
-FSBS was checked TID from 10/12/22- 10/31/22 ranging from 82 to 340.

Review of Resident #1's November 2022 eMAR revealed:
-There was an entry dated 10/12/22 to inject Novolog 5 units before meals at 7:30am, 11:30am and 4:30pm.
-Insulin was not administered on 11/17/22 at 7:30am due to a blood sugar level that was below 100.
-There was no entry to check FSBS, after 10/11/22.
-FSBS was checked TID from 11/01/22- 11/17/22 ranging from 76 to 375.

Interview with the MA on 11/17/22 at 11:32am and 1:55pm revealed:
-Resident #1 was not on a sliding scale for his insulin.
-There was not an order to follow parameters for

a) An audit was completed assuring medications on the eMAR were available for administration on 11/21/22 by DCS/RCC.

b) Weekly cart audits will be completed by the DCS/RCC assuring medications are available for administration.

3) Medication Technicians will be monitored on a random basis during medication administration by the DCS/RCC when present in the community.

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administering Resident #1's insulin.
-She wrote the physician communication requesting parameters on 10/11/22.
-The current order dated 10/11/22 did not have any parameters; it was a scheduled order.
-She did not administer insulin to Resident #1 if his FSBS was below 100, at the family's request.
-She had been following the verbal parameters from the family member for Resident #1's FSBS since 10/11/22.

Interview with a family member on 11/17/22 at 12:27pm revealed she did not inform the facility to hold insulin if Resident #1's FSBS was below 100.

Interview with the Director of Clinical Services on 11/17/22 at 11:44am and 2:49pm revealed:
-She was responsible to ensure medication orders and parameters were accurate.
-She had not conducted a medication order audit.
-If there were orders for parameters, they would be included on the eMAR.
-Reviewing Resident #1's November 2022 eMAR for the Novolog insulin indicated it was a scheduled order to be as administered at 5 units before meals.
-The facility was responsible to ensure medication orders were accurate.
-The facility should not take verbal orders from family members.
-Resident #1 was at risk of having hypoglycemia or hyperglycemia which could cause confusion or the resident to go into diabetic comatose.

Attempted telephone interview with Resident #1's PCP was unsuccessful on 11/17/22 at 12:30pm.

The facility failed to ensure medications were administered as ordered for 1 of 3 sampled

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C-330	Continued From page 4 residents (#1) who had an order for scheduled insulin which could result in confusion or diabetic comatose. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-21 on 11/17/22 for this violation. CORRECTION DATRE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 01, 2023.	C-330		