STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008042	A. BUILDING: _____ B. WING _____	R 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

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{D 000}	Initial Comments The Adult Care Licensure Section and the Bertie County Department of Social Services conducted a follow-up survey September 28, 2023.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE B VIOLATION Based on these findings, the previously Unabated Type B Violation was abated. Non-compliance continues. Based on interviews and record reviews the facility failed to administer medications as ordered for 2 of 3 sampled residents (#1, #3) including a medication used to treat high blood sugar. The findings are: 1. Review of Resident #1's current FL-2 dated 11/09/22 revealed: -Diagnosis included type 2 diabetes. -There was an order for Humalog (a fast acting insulin used to treat high blood sugar) check fingerstick blood sugar (FSBS) 4 times a day and	{D 358}	Facility Manager notified pharmacy and pharmacy coached Facility Manager on adding additional fields in QuickMar for sliding scale ranges; Sliding Scale drop down button that shows the order to help with Med Aide double checking the order, bold notations located beside the field box to ensure that the Medication Aide documents the accurate amount of insulin units to be administered. All Med Aides are aware of the new features added. Facility Manager will audit MAR's every other day instead of weekly to ensure that Med Aides are administering medications as ordered by PCP. Medication Aides will notify PCP about abnormal vitals and blood glucose or incorrect dosage of insulin administered per order. Facility Manager will ensure that medication orders are filed immediately in the resident's chart. Administrator will continue to audit MAR's, Sliding Scale Insulin Log and ensure that Med Aides are preparing and administrating medications, and treatments as order by PCP weekly or as needed. Administrator will audit resident's file weekly to ensure that all medications orders have been filed in the resident's chart. Administrator will observe random medication pass to ensure Med Aides are administering medications on time and correctly. Date of Correction Completion: 10/19/2023	

Reviewed and Acknowledged 10/20/23

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{D 358}	Continued From page 1	{D 358}		

cover with sliding scale insulin (SSI) 0 units for a FSBS of 0-200, 2 units for a FSBS of 201-250, 4 units for a FSBS 251-300, 6 units for a FSBS of 301-350, 8 units for a FSBS of 351-400, 10 units for a FSBS greater than 400.

Review of Resident #1's July 2023 electronic medication administration record (eMAR) revealed:
-There was an order to check FSBS 4 times a day before meals and at bedtime and cover with SSI if FSBS over 200; 0-200= 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400 = 10 units scheduled for administration at 8:00am, 12:00pm, 5:00pm, and 8:00pm.
-Humalog 2 units was documented as administered on 07/20/23 at 8:00pm for a FSBS of 251 when 4 units should have been administered.
-Humalog 4 units was documented as administered on 07/27/23 at 8:00pm for a FSBS of 240 when 2 units should have been administered.

Review of Resident #1's September 2023 eMAR revealed:
-There was an order to check FSBS 4 times a day before meals and at bedtime and cover with SSI if FSBS over 200; 0-200= 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400 = 10 units scheduled for administration at 8:00am, 12:00pm, 5:00pm, and 8:00pm.
-Humalog 2 units was documented as administered on 09/17/23 at 5:00pm for a FSBS of 266 when 4 units should have been administered.
-Humalog 2 units was documented as administered on 09/25/23 at 12:00pm for a FSBS

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{D 358}	Continued From page 2 of 262 when 4 units should have been administered. -Humalog 4 units was documented as administered on 09/25/23 at 5:00pm for a FSBS of 219 when 2 units should have been administered. Interview with Resident #1 on 09/28/23 at 3:48pm revealed: -As far as he knew he always received the correct dosage of Humalog. -He did not recall having any signs and symptoms of a low or high FSBS over the past few months. Interview with a medication aide (MA) on 09/28/23 at 2:23pm revealed: -When a resident was receiving SSI, she checked the resident's FSBS and administered insulin based on what was ordered on the eMAR. -When Resident #1's FSBS was 266 on 09/17/23 she should have administered 4 units of Humalog instead of 2 units of Humalog based on his SSI coverage. -She was not sure why she administered 2 units of Humalog to Resident #1 on 09/17/23 instead of 4 units. Telephone interview with a second MA on 09/28/23 at 3:05pm revealed: -When Resident #1's FSBS was 240 on 07/27/23 she should have administered 2 units of Humalog instead of 4 units. -She did not know why she did not administer 2 units of Humalog to resident #1 but she did not have glasses at the time and may not have seen the numbers correctly. Attempted telephone interview with a third MA on 09/28/23 at 3:04pm was unsuccessful.	{D 358}		

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{D 358}	Continued From page 3 Refer to interview with the RCC on 09/28/23 at 3:56pm. Refer to interview with the Administrator on 09/28/23 at 4:03pm. Refer to telephone interview with the facility's contracted PCP on 09/28/23 at 3:25pm. 2. Review of Resident #3's current FL-2, dated 02/16/23, revealed diagnoses including renal failure and diabetes. Review of physician's orders for Resident #3, dated 02/10/23, revealed: -An order for Novolog 100 unit/ML (a fast-acting insulin used to lower blood sugar) which included medication administration instructions to check fasting serum blood sugar (FSBS) four times a day before meals and at bedtime. -There were instructions to give sliding scale insulin (SSI): 160-199 = 1U, 200-239 = 2U, 240-279 = 3U, 280-310 = 4 U, 320-359 = 5U, 360-399 = 6U, >400 = 6U & notify MD. Review of Resident #3's August 2023 electronic medication administration record (eMAR) revealed: -On 08/30/23 at 11:00am, Resident #3's FSBS was documented as 192 and the resident should have been administered 1 U of Novolog insulin. -There was no documentation that Novolog insulin was administered on 08/30/23 at 11:00am. Interview with the 1st shift MA on 09/28/23 at 3:15pm revealed: -The MA reviewed the documented FSBS for Resident #3 on the 08/30/23 eMAR. -Resident #3's FSBS on 08/30/23 at 11:00am, was documented as 192 and 1 unit of insulin	{D 358}		

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{D 358}	Continued From page 4 should have been administered. -The MA confirmed the insulin was not administered. Telephone interview with Resident #3's primary care provider (PCP) on 9/28/23 at 3:30pm revealed: -She was not aware Resident #3 had not received the ordered amount of insulin on 08/30/23. -She was not aware of any concerns related to Resident #3 experiencing symptoms of high blood sugar on 08/30/23. Interview with the Resident Care Coordinator (RCC) on 09/28/23 at 4:00pm revealed she was not aware Resident #3 was not given the ordered amount of insulin on 08/30/23. Interview with the Administrator on 09/28/23 at 4:05pm revealed she was not aware Resident #3 was not given the ordered amount of insulin on 08/30/23. Refer to interview with the RCC on 09/28/23 at 3:56pm. Refer to interview with the Administrator on 09/28/23 at 4:03pm. Refer to telephone interview with the facility's contracted PCP on 09/28/23 at 3:25pm. _____ Interview with the Resident Care Coordinator (RCC) on 09/28/23 at 3:56pm revealed: -Staff were trained in proper administration of sliding scale insulin (SSI). -She and the Administrator conducted regular electronic medication administration record (eMAR) audits and provided staff training as needed.	{D 358}		

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{D 358}	Continued From page 5 -She expected MAs to read a resident's eMAR and administer insulin based on what the sliding scale said to administer. -MAs should double check what the insulin order was prior to administering SSI to a resident to make sure they were administering the correct amount. Interview with the Administrator on 09/28/23 at 4:03pm revealed: -Staff were trained in proper administration of SSI. -She and the RCC conducted regular eMAR audits and provided staff training as needed. -She expected MAs to read the resident's SSI order prior to administering insulin to make sure they were administering the correct dosage. -It was important that MAs administered the correct dosage of insulin to residents because if a resident received too much insulin their blood sugar could "bottom out" and if a resident did not receive enough insulin their blood sugar could become high. Telephone interview with the facility's contracted primary care provider (PCP) on 09/28/23 at 3:25pm revealed: -She expected MAs to follow SSI parameters and administer the correct dosage of insulin. -If a resident was administered more insulin than they should receive it could cause their blood sugar to become low which could lead to altered mental status or diabetic coma. -If a resident was not administered enough insulin, it could cause them to have a high blood sugar which could lead to long-term complications with their kidneys or eyes or could cause diabetic neuropathy (nerve damage that can occur with diabetes).	{D 358}		