STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060171	A. BUILDING: _____ B. WING _____	R-C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF CHARLOTTE	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey from 10/17/23 to 10/18/23.	{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: Based on interviews and record review, the facility failed to ensure a medication was administered as ordered for 1 of 3 sampled residents (Resident #2) who had a physician's order for sliding scale insulin. Review of Resident #2's current FL2 dated 03/17/22 revealed diagnoses included diabetes mellitus, hypertension, congestive heart failure, chronic kidney disease and lymphedema. Review of Resident #2's signed physician orders dated 10/02/23 revealed Novolog Flexpen 100/mL, inject subcutaneously before meals per sliding scale: Finger Stick Blood Sugar (FSBS): 80-140=2 units, 141-180=4 units, 181-220=5 units, 221-260=6 units, >260=8 units. Review of Resident #2's October 2023 electronic Medication Administration Record (eMAR) revealed: -On 10/06/23 before dinner, his FSBS was 213	{D 358}		

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

and the amount of sliding scale insulin administered was not documented.
-On 10/07/23 before lunch, his FSBS was 116 and the amount of sliding scale insulin administered was not documented.
-On 10/07/23 before dinner, his FSBS was 193 and the amount of sliding scale insulin administered was not documented.
-On 10/08/23 before breakfast, his FSBS was 139 and the amount of sliding scale insulin administered was not documented.
-On 10/08/23 before lunch, his FSBS was 154 and the amount of sliding scale insulin administered was not documented.
-On 10/08/23 before dinner, his FSBS was 241 and the amount of sliding scale insulin administered was not documented.
-On 10/09/23 before breakfast, his FSBS was 227 and the amount of sliding scale insulin administered was not documented.
-On 10/09/23 before lunch, his FSBS was 226 and the amount of sliding scale insulin administered was not documented.
-On 10/09/23 before dinner, his FSBS was 186 and the amount of sliding scale insulin administered was not documented.
-On 10/10/23 before dinner, his FSBS was 231 and the amount of sliding scale insulin administered was not documented.
-On 10/11/23 before breakfast, his FSBS was 208 and the amount of sliding scale insulin administered was not documented.
-On 10/11/23 before lunch, his FSBS was 154 and the amount of sliding scale insulin administered was not documented.
-On 10/11/23 before dinner, his FSBS was 211 and the amount of sliding scale insulin administered was not documented.
-On 10/12/23 before dinner, his FSBS was 292 and the amount of sliding scale insulin

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{D 358}	Continued From page 2	{D 358}		

administered was not documented.
-On 10/13/23 before breakfast, his FSBS was 137 and the amount of sliding scale insulin administered was not documented.
-On 10/13/23 before lunch, his FSBS was 166 and the amount of sliding scale insulin administered was not documented.
-On 10/15/23 before lunch, his FSBS was 162 and the amount of sliding scale insulin administered was not documented.
-On 10/15/23 before dinner, his FSBS was 337 and the amount of sliding scale insulin administered was not documented.
-On 10/16/23 before breakfast, his FSBS was 170 and the amount of sliding scale insulin administered was not documented.
-On 10/16/23 before lunch, his FSBS was 142 and the amount of sliding scale insulin administered was not documented.
-On 10/18/23 before breakfast, his FSBS was 221 and the amount of sliding scale insulin administered was not documented.
-On 10/18/23 before lunch, his FSBS was 149 and the amount of sliding scale insulin administered was not documented.

Interview with Resident #2 on 10/18/23 at 2:56pm revealed:
-He started receiving FSBS's about a month ago and had to get them about 4-5 times a day.
-The staff told him how much he was receiving each time but he did not remember the amounts.
-His blood sugars fluctuated up and down frequently and the staff was always calling his PCP, but he never had any symptoms.

Interview with medication aide (MA) on 10/18/23 at 3:10pm revealed:
-Around 10/06/23, when Resident #2 was ordered the Novolog Flexpen insulin the eMAR allowed

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{D 358}	Continued From page 3	{D 358}		

her to document the units of sliding scale insulin administered in a specific box after she entered his FSBS.
-She was not able to access past eMAR entries of Resident #2's sliding scale insulin to show how many units were administered.
-She was not sure why the units of sliding scale insulin that were administered did not show up when the eMAR was printed.
-She was not able to demonstrate how she documented in the computer because it was not time for Resident #2's FSBS and sliding scale insulin to be administered.

Interview with the Licensed Practical Nurse (LPN) on 10/18/23 at 10:35am revealed she thought Resident #2's units of sliding scale insulin could be seen in the eMAR program.

Interview with the Health and Wellness Director (HWD) on 10/18/23 at 12:28pm and 3:36pm revealed:
-She could not remember when but one of the MAs told her there was not a designated place on the eMAR to document the units of sliding scale insulin administered to Resident #2.
-After she was made aware of the issue, she educated the MAs to document the amount of sliding scale insulin that Resident #2 received in the notes section of the eMAR.
-She was training the LPN to audit the eMARs but was not aware that the majority of the MAs were not documenting the amount of sliding scale insulin that Resident #2 received in the notes section of the eMAR.
-This afternoon (10/18/23), she was able to edit the eMAR to enable a drop box for the units of sliding scale insulin that were administered to be documented.

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{D 358}	Continued From page 4 Telephone interview with a representative from the facility's contracted pharmacy on 10/18/23 at 2:48pm revealed: -Resident #2's current sliding scale insulin order was Novolog 100/ml, check FSBS before each meal and inject per sliding scale: FSBS: 80-140 = 2 units, 141-180 = 4 units, 181-220 = 5 units, 221-260 = 6 units, above 260 inject 8 units. -If too little or too much sliding scale insulin was administered, the resident could be lethargic (having little energy) and if he received too little for an extended amount of time, he could have muscle degeneration. -Novolog one 3ml (100 units/ml) pen was last dispensed for Resident #2 on 10/02/23. Interview with the Administrator on 10/18/23 at 4:13pm revealed: -He expected the physician's orders to be followed as they were written and for the medications that were administered to be documented on the eMAR. -He expected all of the resident's eMARs to be audited by the LPN daily and would have expected the missing units of sliding scale insulin to be caught while auditing. Attempted interview with Resident #2's Primary Care Provider (PCP) on 10/18/23 at 2:39pm was unsuccessful.	{D 358}		