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 _____	R 01/04/2024

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 01/03/24 - 01/04/24 with an exit conference via telephone on 01/04/24.	{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 TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#1 and #3) related to a medication to treat diabetes (#1), and a hormone supplement (#3). The findings are: Review of the facility's undated Medication Administration Policy and Procedure on 01/03/24 revealed medications, prescription and non-prescription, and treatments, would be administered in accordance with the prescribing	{D 358}		

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{D 358}	Continued From page 1 practitioner's orders. 1. Review of Resident #1's current FL2 dated 09/14/22 revealed diagnoses included diabetes. Review of Resident #1's physician's orders dated 09/20/23 revealed Aspart insulin (medication used to treat diabetes) inject sliding scale insulin (SSI) 4 times daily with meals and at bedtime; for finger stick blood sugar (FSBS) parameters of 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, greater than 400 give 0 units and call physician for instructions. Review of Resident #1's physician's orders dated 10/20/23 revealed additional Aspart insulin for FSBS parameters of 401-450 = 6 units, 451-500 = 7 units, and greater than 501 send to the ED. Review of Resident #1's medication administration record (MAR) for December 2023 revealed: -There was an entry for Aspart insulin inject 4 times daily with meals and at bedtime for finger stick blood sugar (FSBS) parameters 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, 401-450 = 6 units, 451-500 = 7 units, and greater than 501 send to the emergency department (ED), with administration times of 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation of a FSBS of 147 on 12/03/23 at 4:00pm and 1 unit of insulin was administered (no SSI should have been administered). -There was documentation of a FSBS of 56 on 12/04/23 at 4:00pm and 6 units of insulin was administered (no SSI should have been administered).	{D 358}		

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{D 358}	Continued From page 2 -There was documentation of a FSBS of 154 on 12/08/23 at 12:00pm and 2 units of insulin was administered (1 unit should have been administered). -There was documentation of a FSBS of 256 on 12/09/23 at 8:00pm and 2 units of insulin was administered (3 units should have been administered). -There was documentation of a FSBS of 215 on 12/18/23 at 12:00pm and no insulin was administered (2 units should have been administered). -There was documentation of a FSBS of 232 on 12/18/23 at 8:00pm and 3 units of insulin was administered (2 units should have been administered). -There was documentation of a FSBS of 344 on 12/19/23 at 8:00am and 5 units of insulin was administered (4 units should have been administered). -There was documentation of a FSBS of 206 on 12/21/23 at 8:00am and 1 unit of insulin was administered (2 units should have been administered). -There was documentation of a FSBS of 206 on 12/21/23 at 12:00pm and 1 unit of insulin was administered (2 units should have been administered). -There was documentation of a FSBS of 292 on 12/21/23 at 4:00pm and 1 unit of insulin was administered (3 units should have been administered). -There was documentation of a FSBS of 191 on 12/21/23 at 8:00pm and 3 units of insulin was administered (1 unit should have been administered). -There was documentation of a FSBS of 201 on 12/22/23 at 4:00pm and 1 unit of insulin was administered (2 units should have been administered).	{D 358}		

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{D 358}	Continued From page 3 -There was documentation of a FSBS of 204 on 12/22/23 at 8:00pm and 1 unit of insulin was administered (2 units should have been administered). -There was documentation of a FSBS of 232 on 12/23/23 at 8:00pm and 3 units of insulin was administered (2 units should have been administered). -There was documentation of a FSBS of 219 on 12/25/23 at 12:00pm and 1 unit of insulin was administered (2 units should have been administered). -There was documentation of a FSBS of 116 on 12/29/23 at 8:00pm and 1 unit of insulin was administered (no SSI should have been administered). -There were 98 instances of the FSBS reading being 151 or greater between 12/01/23 - 12/31/23 with 13 doses of Aspart SSI documented as administered incorrectly. -There were 21 instances of the FSBS reading being 150 or less between 12/01/23 - 12/31/23 with 3 doses of Aspart SSI documented as administered when no SSI should have been administered. Observation of Resident #3's medications available for administration on 01/03/24 at 11:12am revealed there was one tube of estradiol cream with 2/3 of the cream left in the tube. Interview with the Resident Care Coordinator (RCC) on 01/03/24 at 2:14pm revealed: -She was trained to read the SSI to determine the dose of insulin to administer. -She did not know why she administered incorrect doses of SSI to Resident #1. -She may have incorrectly read the SSI. -She always read the order after obtaining the FSBS reading and wrote down how much SSI to	{D 358}		

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{D 358}	Continued From page 4 administer. Interview with the medication aide (MA) on 01/03/24 at 2:20pm revealed: -She knew how much SSI to administer based on the FSBS readings. -She might have written down how much she administered incorrectly. -She would converse with Resident #1 during the FSBS checks and inform him how much SSI she would administer. Interview with the Administer on 01/03/24 at 2:31pm revealed: -The MAs were trained to administer the SSI based on the FSBS readings. -The facility's contracted nurse reviewed the MARs and should have "caught that". -She did not know why the MAs administered the SSI incorrectly. Telephone interview with a Registered Nurse (RN) at a local diabetic clinic on 01/03/24 at 2:41pm revealed: -Resident #1 was assessed at the diabetic clinic by the physician every 4 -6 months. -The clinic received multiple phone calls from staff at the facility during the month of December 2023 with questions regarding Resident #1's FSBS readings. -The physician at the diabetic clinic gave strict orders about the SSI and instructed staff to telephone Resident #1's primary care provider (PCP) for any other questions. Telephone interview with the facility's contracted RN on 01/04/24 at 11:17am revealed: -She went to the facility every two weeks to review MARs, physician orders, and conduct medication cart audits.	{D 358}		

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{D 358}	Continued From page 5 -She did not review Resident #1's FSBS readings or insulin administered when she was last in the facility on 12/28/23. -She conducted multiple trainings since October 2023 with the staff in the facilty regarding Resident #1's SSI because staff administered the SSI incorrectly. -She did not know why staff administered incorrect doses of SSI to Resident #1. Interview with Resident #1 on 01/03/24 at 11:17am revealed: -Staff checked his FSBS readings and administered his SSI. -He thought staff was administering the correct doses of SSI. Attempted telephone interviews with Resident #1's PCP on 01/03/24 at 2:40pm and 01/14/24 at 9:37am were unsuccessful. 2. Review of Resident #3's current FL2 dated 12/08/23 revealed diagnoses included hypertension and history of urinary tract infection. Review of physician's orders for Resident #3 dated 12/08/23 revealed estradiol (hormone supplement) 0.01% cream apply 1 gram vaginally Monday, Wednesday, and Friday for 21 days hold for 7 days, and repeat cycle. Review of Resident #3's electronic Medication Administration Record (eMAR) for 12/01/23 - 12/31/23 revealed: -The was an entry for estradiol 0.01% cream apply 1 gram vaginally Monday, Wednesday, and Friday for 21 days, withhold for 7 days, and repeat cycle, with an administration time of 8:00am. -There was documentation the estradiol 0.01%	{D 358}		

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{D 358}	Continued From page 6 cream was administered on 12/05/23, 12/10/23, 12/15/23, 12/20/23, and 12/25/23 (every 5 days) at 8:00am. Review of Resident #3's electronic Medication Administration Record (eMAR) for 01/01/24 - 01/03/24 revealed: -The was an entry for estradiol 0.01% cream apply 1 gram vaginally Monday, Wednesday, and Friday for 21 days, withhold for 7 days, and repeat cycle, with an administration time of 8:00am. -There was no documentation the estradiol was administered on 01/01/24 or 01/03/24. Interview with a representative from the facility's contracted pharmacy on 01/03/24 at 11:50am revealed: -The pharmacy received an original order for estradiol 0.01% cream apply 1 gram vaginally Monday, Wednesday, and Friday for 21 days, withhold for 7 days, and repeat cycle on 07/18/23. -The pharmacy dispensed 9 grams of the estradiol cream on 07/18/23 which would last 5 months and it should have been refilled. Interview with the Resident Care Coordinator (RCC) on 01/03/24 at 2:45pm revealed: -She was responsible for reviewing the eMARS monthly to ensure they were correct. -She usually reviewed them between the 1st and 6th of every month. -She missed the error with the administration days of the estradiol cream. Interview with the Administrator on 01/03/24 at 11:08am revealed: -The RCC was responsible for reviewing the eMARs to ensure they matched the physician's orders.	{D 358}		

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{D 358}	Continued From page 7 -The RCC should have notified the pharmacy to verify the order and rewritten it on the eMAR correctly. Interview with Resident #3 on 01/03/24 at 2:12pm revealed: -She could have the estradiol cream if she asked staff, but she had not asked in 3 or 4 months. -She did not know the physician wanted her to have the estradiol cream 3 times a week and she would be ok with that.	{D 358}		
{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 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:	{D 367}		

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{D 367}	Continued From page 8 FOLLOW UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 3 sampled residents (#3) related to a hormone supplement. The findings are: Review of Resident #3's current FL2 dated 12/08/23 revealed diagnoses included hypertension and history of urinary tract infection. Review of physician's orders for Resident #3 dated 12/08/23 revealed estradiol (hormone supplement) 0.01% cream apply 1 gram vaginally Monday, Wednesday, and Friday for 21 days then hold for 7 days and then repeat cycle. Review of Resident #3's electronic Medication Administration Record (eMAR) for 12/01/23 - 12/31/23 revealed: -The was an entry for estradiol 0.01% cream apply 1 gram vaginally Monday, Wednesday, and Friday for 21 days then withhold for 7 days and then repeat cycle. -There was an entry for an administration time of 8:00am on Wednesday and Friday with dates for administration of 12/05/23, 12/10/23, 12/15/23, 12/20/23, 12/25/23, and 12/30/23 (every 5 days). Review of Resident #3's electronic Medication Administration Record (eMAR) for 01/01/24 - 01/03/24 revealed: -The was an entry for estradiol 0.01% cream apply 1 gram vaginally Monday, Wednesday, and	{D 367}		

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{D 367}	Continued From page 9 Friday for 21 days then withhold for 7 days and then repeat cycle. -There was an entry for an administration time of 8:00am on Wednesday and Friday with an "x" on 01/01/24, 01/02/24, and 01/03/24. Interview with a representative from the facility's contracted pharmacy on 01/03/24 at 11:50am revealed: -The pharmacy received an original order for estradiol 0.01% cream apply 1 gram vaginally Monday, Wednesday, and Friday for 21 days then withhold for 7 days and then repeat cycle on 07/18/23. -The pharmacy made an error with the estradiol administration days on the MAR. Interview with the Resident Care Coordinator (RCC) on 01/03/24 at 2:45pm revealed: -She was responsible for reviewing the eMARS monthly to ensure they were correct. -She usually reviewed them between the 1st and 6th of every month. -She missed the error with the administration days of the estradiol cream. Interview with the Administrator on 01/03/24 at 11:08am revealed: -The RCC was responsible for reviewing the eMARs to ensure they matched the physician's orders. -The RCC should have notified the pharmacy to verify the order and rewritten it on the eMAR correctly.	{D 367}		