STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 an annual and follow-up survey from 05/22/24 to 05/23/24.	D 000	Response to the cited deficiencies does not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with State Law.	
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 record reviews and interviews, the facility failed to administer medications as ordered to 2 of 5 sampled residents (#1, #3)including medications used to treat diabetes (#1) and increase urinary flow (#3). The findings are: 1. Review of the Resident #1's FL-2 dated 01/18/24 revealed: -Diagnoses included type 2 diabetes, hypertension, coronary artery disease (CAD), congestive heart failure (CHF), gastroesophageal reflux disease (GERD), hyperlipidemia, and osteoarthritis. -There was an order for Humulin R Regular U-100 Insulin solution; 100unit/ml; per sliding scale; if blood sugar is 0 to 150, give 0 units; if blood sugar was 151 to 199, give 2 units; if blood sugar was 200 to 249, give 4 units; if blood sugar was 250 to 299, give 6 units; if blood sugar was	D 358	D358 .1004 (a) 1,2 RCC or ED will run EMAR compliance reports daily for 30 days then weekly to review for compliance and accuracy, as well as review of any residents on sliding scale insulin. This report will be discussed with the RCC and ED in management meeting for follow up. Ongoing. RCC will complete a minimum of 2% chart reviews weekly for 30 days then 100% quarterly to audit for compliance and accuracy. Charts will be submitted to the ED upon completion. Ongoing.	D358 .1004 (a) 1,2 6/30/24 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura H. Anderson, ED. | TITLE | (X6) DATE: 7-1-24

Reviewed and Acknowledged 07/01/24 Laura A Hayes

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D 358	Continued From page 1 300 to 350, give 8 units; if blood sugar was greater than 350, give 10 units; if blood sugar was greater than 400, call MD , inject as directed on sliding scale before meals and at bedtime. (Humulin insulin is used for the management of diabetes mellitus type 1 and type 2 to improve glycemic control). Review of Resident #1's physician's orders dated 03/27/24 revealed there was an order for Humulin R Regular U-100 Insulin solution; inject as directed per sliding scale; three times per day; if blood sugar is 0 to 150, give 0 units; if blood sugar was 151 to 199, give 2 units; if blood sugar was 200 to 249, give 4 units; if blood sugar was 250 to 299, give 6 units; if blood sugar was 300 to 350, give 8 units; if blood sugar was greater than 350, give 10 units; if blood sugar was greater than 400, call MD. Review of Resident #1's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Humulin R Regular U-100 Insulin solution; inject as directed per sliding scale; three times per day; if blood sugar is 0 to 150, give 0 units; if blood sugar was 151 to 199, give 2 units; if blood sugar was 200 to 249, give 4 units; if blood sugar was 250 to 299, give 6 units; if blood sugar was 300 to 350, give 8 units; if blood sugar was greater than 350, give 10 units; if blood sugar was greater than 400, call MD scheduled for 7:30am, 11:30am, and 4:30pm. -There was an entry on 03/19/24 at 4:30pm the blood sugar reading was 201; 2 units of Humulin insulin were documented as administered. -According to the sliding scale 4 units of Insulin should have been administered for a reading of 201. -There was an entry on 03/20/24 at 11:30am the	D 358		

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D 358	Continued From page 2 blood sugar reading was 558; 4 units Humulin insulin were documented as administered. -According to the sliding scale 10 units of insulin should have been administered for a reading of 558. -There was an entry on 03/28/24 at 4:30pm the blood sugar reading was 361; 6 units of Humulin insulin were documented as administered. -According to the sliding scale 10 units of insulin should have been administered for a reading of 361. -There was an entry on 03/29/24 at 11:30am the blood sugar reading was 360; 6 units of Humulin insulin were documented as administered. -According to the sliding scale 10 units of insulin should have been administered for a reading of 360. Review of Resident #1's physician's order dated 03/20/24 revealed: -There was a notification of a blood sugar reading of 558. -Give 12 units insulin now. -Check blood sugar again in 3 hours. Review of Resident #1's April 2024 eMAR revealed: -There was an entry for Humulin R Regular U-100 Insulin solution; inject as directed per sliding scale; three times per day; if blood sugar is 0 to 150, give 0 units; if blood sugar was 151 to 199, give 2 units; if blood sugar was 200 to 249, give 4 units; if blood sugar was 250 to 299, give 6 units; if blood sugar was 300 to 350, give 8 units; if blood sugar was greater than 350, give 10 units; if blood sugar was greater than 400, call MD. scheduled for 7:30am, 11:30am, and 4:30pm. -There was an entry on 04/15/24 at 4:30pm the blood sugar reading was 307; 6 units of Humulin insulin were documented as administered.	D 358		

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D 358	Continued From page 3 -According to the sliding scale 8 units of insulin should have been administered for a reading of 307. -There was an entry on 04/17/24 at 11:30am the blood sugar reading was 283; 4 units of Humulin insulin were documented as administered. -According to the sliding scale 6 units of insulin should have been administered for a reading of 283. -There was an entry on 04/24/24 at 11:30am the blood sugar reading was 199; 1 unit of Humulin insulin was documented as administered. -According to the sliding scale 2 units of insulin should have been administered for a reading of 199. Review of Resident #1's May 2024 eMAR revealed: -There was an entry for Humulin R Regular U-100 Insulin solution; inject as directed per sliding scale; three times per day; if blood sugar is 0 to 150, give 0 units; if blood sugar was 151 to 199, give 2 units; if blood sugar was 200 to 249, give 4 units; if blood sugar was 250 to 299, give 6 units; if blood sugar was 300 to 350, give 8 units; if blood sugar was greater than 350, give 10 units; if blood sugar was greater than 400, call MD. scheduled for 7:30am, 11:30am, and 4:30pm. -There was an entry on 05/01/24 at 11:30am the blood sugar reading was 161; 4 units of Humulin insulin were documented as administered. -According to the sliding scale 2 units of insulin should have been administered for a reading of 161. -There was an entry on 05/07/24 at 7:30am the blood sugar reading was 114; 2 units of Humulin insulin were documented as administered. -According to the sliding scale 0 units of insulin should have been administered for a reading of 114.	D 358		

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D 358	Continued From page 4 -There was an entry on 05/08/24 at 4:30pm the blood sugar reading was 176; 4 units of Humulin insulin were documented as administered. -According to the sliding scale 2 units of insulin should have been administered for a reading of 176. -There was an entry on 05/23/24 at 4:30pm the blood sugar reading was 178; 3 units of Humulin insulin were documented as administered. -According to the sliding scale 2 units of insulin should have been administered for a reading of 178. Interview with the medication aide (MA) on 05/23/24 at 10:15am revealed: -She checked Resident #1's blood sugar. -She placed Resident #1's blood sugar reading into the eMAR system. -Based on the reading the eMAR system generated the number of insulin units to administer. -She administered the insulin units according to the eMAR system and typed the number of insulin units administered into the eMAR system. -She was certain she administered the accurate amount of insulin to Resident #1. -She always looked back at the eMAR to ensure she was administering the correct amount of insulin units. -She did not know why the insulin units were different from what should have been administered according to the sliding scale. Interview with the Resident Care Coordinator (RCC) on 05/23/24 at 10:33am revealed: -The MAs were responsible for administering insulin. -The MAs should check the resident's blood sugar and place the reading of the blood sugar in the eMAR system.	D 358		

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D 358	Continued From page 5 -The eMAR system allowed the number of units to administer to pop up and that indicated to the MAs the number of insulin units to administer. -The MAs should look on the eMAR to know what units to administer as well. Interview with the Administrator on 05/23/24 at 10:33am revealed: -She completed a chart audit for another resident to ensure their parameters were being followed accurately but she did not complete a chart audit for Resident #1. -She expected the MAs to administer Resident #1's insulin correctly. 2. Review of Resident #3's current FL-2 dated 01/23/24 revealed diagnoses included hypertension, hyperlipidemia, mild memory loss, malaise, and fatigue. Review of Resident #3's current physician order sheet dated 03/27/24 revealed an order for Tamsulosin 0.4mg once daily (Tamsulosin is used to increase urinary flow). Review of Resident #3's pharmacy drug review dated 04/03/24 and signed by the facility's contracted primary care provider (PCP) on 04/10/24 revealed: -The pharmacist recommended changing the administration time for Tamsulosin to bedtime ideally 30 minutes after dinner to reduce the risk of adverse events and maximize efficacy. -The facility's current PCP checked that he accepted the recommended change from the pharmacist. -There was a stamp (FAXED to pharmacy on 4/10) on the upper right-hand corner on the pharmacy drug review document that was signed by the PCP dated 04/10/24, there was also on the	D 358		

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D 358	Continued From page 6 right middle of the document a stamp which read "SCANNED". Review of Resident #3's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Tamsulosin 0.4 mg once daily at 9:00am. -Tamsulosin was documented as administered 03/01/24 through 03/31/24 at 9:00am. Review of Resident #3's April 2024 eMAR revealed: -There was an entry for Tamsulosin 0.4 mg once daily at 9:00am. -Tamsulosin was documented as administered 04/01/24 through 04/10/24 at 9:00am and 04/16/24 through 04/30/24 at 9:00am. -There was an entry for Tamsulosin 0.4 mg once daily at 8:00pm. -Tamsulosin was documented as administered 04/11/24 through 04/15/24 at 8:00pm Review of Resident #3's May 2024 eMAR revealed: -There was an entry for Tamsulosin 0.4 mg once daily at 9:00am. -Tamsulosin was documented as administered 05/01/24 through 05/22/24 at 9:00am. Review of Resident #3's medications on hand on 05/22/24 at 3:18pm revealed: -Tamsulosin 0.4mg was dispensed by the pharmacy on 05/17/24. -There was 4 Tamsulosin 0.4mg's left in the am pack of medications. Interview with the medication aide (MA) on 05/22/24 at 2:10pm revealed: -Tamsulosin 0.4mg was packaged in the am pack	D 358		

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D 358	Continued From page 7 with her other medications. -She did not know why the April 2024 eMARs showed that the medication was administered at 8:00pm for 5 days. -She had only administered Tamsulosin in the am. -The pharmacy completed the eMARs. Interview with the Resident Care Coordinator (RCC) on 05/22/24 revealed: -She reviewed Resident #3's pharmacy drug review when she received it on 04/03/24 and placed it in the providers folder for review. -The PCP signed the pharmacy drug review on 04/10/24. -She faxed the signed pharmacy drug review to pharmacy on 04/10/24. -The pharmacy entered new orders on the eMARs. -Changes to medications were entered by the pharmacy and she accepted the changes daily. -She was able to change the times a medication was administered on the eMARs. -She did not know why Tamsulosin was not packaged by the pharmacy in Resident #3's pm medications. Interview with the Administrator on 05/22/24 at 3:43pm revealed: -The pharmacy sent the pharmacy drug review through the electronic medical record to both her and the RCC when completed. -When there was a recommendation for the PCP it was sent to the PCP, and they would sign and send it back. -The signed pharmacy drug review was then sent to the pharmacy. -The pharmacy completed the order, and the facility approved the change. -The pharmacy entered the orders onto the	D 358		

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D 358	Continued From page 8 eMARs. -There was a folder to place all pharmacy review orders that had been sent to pharmacy and the folder was reviewed. If the orders had not been completed the pharmacy was called. -She was not sure why their process had not been followed. -The RCC had been educated on this process. Interview with the contracted pharmacy technician on 05/22/24 at 2:15pm revealed: -Resident #3's Tamsulosin 0.4 mg change to administered at 8:00pm was made in the system on 04/10/24. -The medication change was made during an open batch and the system automatically changed the order back to 9:00am. Interview with the facility's contracted pharmacist on 05/22/24 at 2:20pm revealed: -The pharmacy had received the order to change Resident #3's Tamsulosin administration time to 8:00pm on 04/10/24. -Tamsulosin 0.4mg was not updated in their system because it could not be updated during a current batch. -She thought that there was an error in the system that the time was not changed. -Resident #3 could experience syncope, dizziness, a drop in blood pressure upon standing. These symptoms could cause her to fall, and the fall could have no injuries to serious injuries when Tamsulosin was administered in the am instead of the pm. Interview with the facility's contracted provider (PCP) on 05/23/24 at 8:00am revealed: -She did not know that the administration time for Tamsulosin 0.4mg was not changed from 9:00am to 8:00pm.	D 358		

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D 358	Continued From page 9 -Resident #3 could have orthostatic changes in her blood pressure upon standing. -Resident #3 could have dizziness and lightheadedness which could have made her fall. -The falls could have caused no injuries or serious injuries that she would have had to be treated in the emergency department when Tamsulosin was administered in the am instead of the pm. Interview with Resident #3 on 05/22/24 at 4:00pm revealed: -She did not know the names of her medications. -She had fallen several times in the past but did not know the dates.	D 358		