STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	360 WOOD ROAD TAYLORSVILLE, NC 28681

(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 Alexander County Department of Social Services conducted an annual survey on July 10, 2024 through July 11, 2024.	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 reviews, the facility failed to ensure medications were administered as prescribed for 1 of 1 residents (Resident #1) related to a medication used to control elevated blood sugar. The finding are: Review of Resident #1's current FL2 dated 06-05-24 revealed: -Diagnoses included schizoaffective disorder, opioid dependence, hypertension, and diabetes. -He was oriented. -He did not need any personal care assistance. Review of Resident #1's Resident Register dated 08/17/16 revealed: -Resident #1 was admitted to the facility on 08/12/24. -He was his own responsible party.	D 358		

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D 358	Continued From page 1 Interview with Resident #1 on 07/11/24 at 10:20am revealed: -He always watched when the MA did his FSBS and knew how much insulin would be given. -He refused his night FSBS and insulin quite a bit because he was tired and usually sleeping at 8:00pm. -He could not remember a time when the MA did a FSBS and did not give sliding scale insulin if it was needed. -He stated there were many times his FSBS would be below 150 and he would not need the sliding scale insulin. Review of Resident #1's signed Physician orders dated 06/20/24 revealed: -There was an order to check finger stick blood sugar (FSBS) four times a day at 6:00am, 11:30am, 4:30pm and 8:00pm. -There was an order for Novolog insulin Flexpen 100 units, (a rapid acting insulin used to lower elevated blood sugar levels), inject per sliding scale: FSBS: 0-150 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units and over 450 give 12 units and call the Primary Care Physician (PCP). Review of Resident #1's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog insulin Flexpen 100 units, inject per sliding scale at 6:00am, 11:30am, 4:30pm and 8:00pm. -On 05/02/24 at 4:40pm, the resident's FSBS was 234 and there was no Novolog insulin documented as administered when the order stated he should have received 4 units. -On 05/04/24 at 4:30pm, the resident's FSBS was	D 358		

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D 358	Continued From page 2	D 358		

177 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.
-On 05/05/24 at 11:30am, the resident's FSBS was 397 and there was no Novolog insulin documented as administered when the order stated he should have received 10 units.
-On 05/06/24 at 11:30am, the resident's FSBS was 196 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.
-On 05/07/24 at 4:30pm, the resident's FSBS was 233 and there was no Novolog insulin documented as administered when the order stated he should have received 4 units.
-On 05/12/24 at 4:30pm, the resident's FSBS was 260 and there was no Novolog insulin documented as administered when the order stated he should have received 6 units.
-On 05/13/24 at 4:30pm, the resident's FSBS was 158 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.
-On 05/15/24 at 6:00am, the resident's FSBS was 169 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.
-On 05/19/24 at 6:00am, the resident's FSBS was 155 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.
-On 05/22/24 at 6:00am, the resident's FSBS was 233 and there was no Novolog insulin documented as administered when the order stated he should have received 4 units.
-On 05/22/24 at 4:30pm, the resident's FSBS was 189 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.
-On 05/22/24 at 8:00pm, the resident did not have

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D 358	Continued From page 3 a FSBS documented. -On 05/24/24 at 4:30pm, the resident's FSBS was 170 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 05/25/24 at 4:30pm, the resident's FSBS was 315 and there was no Novolog insulin documented as administered when the order stated he should have received 8 units. -On 05/26/24 at 4:30pm, the resident's FSBS was 159 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 05/27/24 at 4:30pm, the resident's FSBS was 152 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. Review of Resident #1's June 2024 eMAR revealed: -On 06/15/24 at 6:00am, the resident's FSBS was 169 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 06/19/24 at 8:00pm, the resident's FSBS was 184 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 06/27/24 at 11:30am, the resident's FSBS was 174 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 06/29/24 at 6:00am, the resident's FSBS was 157 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. Review of Resident #1's July 2024 eMAR revealed: -On 07/04/24 at 6:00am, the resident's FSBS was	D 358		

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D 358	Continued From page 4 152 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 07/25/24 at 6:00am, the resident's FSBS was 203 and there was no Novolog insulin documented as administered when the order stated he should have received 4 units. -On 07/08/24 at 11:30am, the resident's FSBS was 293 and there was no Novolog insulin documented as administered when the order stated he should have received 6 units. -On 07/09/24 at 6:00am, the resident's FSBS was 200 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/11/24 at 11:59am revealed: -Resident #1 had an order for Novolog insulin Flexpen 100 units, (a rapid acting insulin used to lower elevated blood sugar levels), inject per sliding scale: FSBS: 0-150 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units and over 450 give 12 units and call the PCP. -On 04/15/24, five pens of Novolog insulin Flexpen 100 units, three milliliters each, were dispensed to Resident #1. -On 06/13/24, five pens of Novolog insulin Flexpen 100 units, three milliliters each, were dispensed to Resident #1. -Audits were completed quarterly by a Pharmacist. -The audits consisted of looking at orders, discontinued medications, and charting of medications. -The audits did not consist of checking FSBS with what sliding scale insulin was given.	D 358		

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D 358	Continued From page 5 -If a resident did not receive sliding scale insulin, it could cause sweating, headaches, shakiness and feeling tired. -If a resident received too much sliding scale insulin, it could cause dry mouth and thirst. Interview with a medication aide (MA) on 07/11/24 at 11:32am revealed: -She was not aware there were times Resident #1 did not get his sliding scale insulin. -Resident #1 refused many of his medications at times but always knew what his FSBS was and knew how much insulin was to be given. -The computer prompts us on how much sliding scale insulin should be given and does not allow us to move forward in the system unless we put how much sliding scale insulin was given. -All MA's received a class on diabetic training and sliding scale insulin prior to working as a MA in the facility. -She thought audits were done on charts for missed medications and out of date medications but was not sure. Interview with the Resident Care Coordinator (RCC) on 07/11/24 at 11:55am revealed: -She was not aware of sliding scale insulin being missed on the May, June, and July eMAR's for Resident #1. -She thought she received a missed medication report but never saw areas where sliding scale insulin was missing. -All MA's had diabetic training which included education on how to administer sliding scale insulin prior to starting on the medication carts. -She would occasionally audit FSBS to sliding scale insulin but not on a consistent basis. Interview with the Administrator on 07/11/24 at 12:30pm revealed:	D 358		

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D 358	Continued From page 6 -She was not aware of sliding scale insulin being missed on the May, June, and July eMAR's for Resident #1. -She and the RCC audited the charts monthly and had checked Resident #1's FSBS and sliding scale insulin to the orders. -She could not understand how the FSBS was there but no sliding scale insulin to cover it because she was told you could not finish the medication pass unless all blanks were checked off. -She and the Pharmacist had already set up a time to fix this issue. Attempted telephone interview with Resident #1's PCP on 07/11/24 at 10:44am was unsuccessful.	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	D 367		

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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:
Based on interviews and record reviews, the facility failed to ensure electronic medication administration records (eMAR) were accurate for 1 of 1 residents (Resident #1) related to documenting the amount of sliding scale insulin administered.

The finding are:

Review of the facility's Medication Administration Policy revealed:
-The eMAR must be kept current with all drugs administered.
-Each residents' medication must be recorded immediately after administered.

Review of Resident #1's current FL2 dated 06-05-24 revealed:
-Diagnoses included schizoaffective disorder, opioid dependence, hypertension, and diabetes.
-He was oriented.
-He did not need any personal care assistance.

Review of Resident #1's Resident Register dated 08/17/16 revealed:
-Resident #1 was admitted to the facility on 08/12/24.
-He was his own responsible party.

Interview with Resident #1 on 07/11/24 at 10:20am revealed:
-He always watched when the MA did his FSBS and knew how much insulin would be given.
-He refused his night FSBS and insulin quite a bit because he was tired and usually sleeping at

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D 367	Continued From page 8 8:00pm. -He could not remember a time when the MA did a FSBS and did not give sliding scale insulin if it was needed. -He stated there were many times his FSBS would be below 150 and he would not need the sliding scale insulin. Review of Resident #1's signed Physician orders dated 06/20/24 revealed: -There was an order to check finger stick blood sugar (FSBS) four times a day at 6:00am, 11:30am, 4:30pm and 8:00pm. -There was an order for Novolog insulin Flexpen 100 units, (a rapid acting insulin used to lower elevated blood sugar levels), inject per sliding scale: FSBS: 0-150 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units and over 450 give 12 units and call the Primary Care Physician (PCP). Review of Resident #1's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog insulin Flexpen 100 units, inject per sliding scale at 6:00am, 11:30am, 4:30pm and 8:00pm. -On 05/02/24 at 4:40pm, the resident's FSBS was 234 and there was no Novolog insulin documented as administered when the order stated he should have received 4 units. -On 05/04/24 at 4:30pm, the resident's FSBS was 177 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 05/05/24 at 11:30am, the resident's FSBS was 397 and there was no Novolog insulin documented as administered when the order stated he should have received 10 units.	D 367		

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D 367	Continued From page 9 -On 05/06/24 at 11:30am, the resident's FSBS was 196 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 05/07/24 at 4:30pm, the resident's FSBS was 233 and there was no Novolog insulin documented as administered when the order stated he should have received 4 units. -On 05/12/24 at 4:30pm, the resident's FSBS was 260 and there was no Novolog insulin documented as administered when the order stated he should have received 6 units. -On 05/13/24 at 4:30pm, the resident's FSBS was 158 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 05/15/24 at 6:00am, the resident's FSBS was 169 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 05/19/24 at 6:00am, the resident's FSBS was 155 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 05/22/24 at 6:00am, the resident's FSBS was 233 and there was no Novolog insulin documented as administered when the order stated he should have received 4 units. -On 05/22/24 at 4:30pm, the resident's FSBS was 189 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 05/22/24 at 8:00pm, the resident did not have a FSBS documented. -On 05/24/24 at 4:30pm, the resident's FSBS was 170 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. -On 05/25/24 at 4:30pm, the resident's FSBS was 315 and there was no Novolog insulin	D 367		

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D 367	Continued From page 10	D 367		

documented as administered when the order stated he should have received 8 units.
-On 05/26/24 at 4:30pm, the resident's FSBS was 159 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.
-On 05/27/24 at 4:30pm, the resident's FSBS was 152 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.

Review of Resident #1's June 2024 eMAR revealed:
-On 06/15/24 at 6:00am, the resident's FSBS was 169 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.
-On 06/19/24 at 8:00pm, the resident's FSBS was 184 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.
-On 06/27/24 at 11:30am, the resident's FSBS was 174 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.
-On 06/29/24 at 6:00am, the resident's FSBS was 157 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.

Review of Resident #1's July 2024 eMAR revealed:
-On 07/04/24 at 6:00am, the resident's FSBS was 152 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units.
-On 07/25/24 at 6:00am, the resident's FSBS was 203 and there was no Novolog insulin documented as administered when the order stated he should have received 4 units.

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D 367	Continued From page 11 -On 07/08/24 at 11:30am, the resident's FSBS was 293 and there was no Novolog insulin documented as administered when the order stated he should have received 6 units. -On 07/09/24 at 6:00am, the resident's FSBS was 200 and there was no Novolog insulin documented as administered when the order stated he should have received 2 units. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/11/24 at 11:59am revealed: -Resident #1 had an order for Novolog insulin Flexpen 100 units, (a rapid acting insulin used to lower elevated blood sugar levels), inject per sliding scale: FSBS: 0-150 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units and over 450 give 12 units and call the PCP. -On 04/15/24, five pens of Novolog insulin Flexpen 100 units, three milliliters each, was dispensed to Resident #1. -On 06/13/24, five pens of Novolog insulin Flexpen 100 units, three milliliters each, was dispensed to Resident #1. -Audits were completed quarterly by a Pharmacist. -The audits consisted of looking at orders, discontinued medications, and charting of medications. -The audits did not consist of checking FSBS with what sliding scale insulin was given. -If a resident did not receive sliding scale insulin, it could cause sweating, headaches, shakiness and feeling tired. -If a resident received too much sliding scale insulin, it could cause dry mouth and thirst. Interview with a medication aide (MA) on 07/11/24	D 367		

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HERITAGE CARE HOME OF TAYLORSVILLE	360 WOOD ROAD TAYLORSVILLE, NC 28681

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D 367	Continued From page 12 at 11:32am revealed: -She was not aware there were times Resident #1 did not get his sliding scale insulin. -She was not aware there were blanks on the eMAR where the sliding scale should have been documented. -Resident #1 refused many of his medications at times but always knew what his FSBS was and knew how much insulin was to be given. -The computer prompted us on how much sliding scale insulin should be given with a place to document it. -The system does not allow us to move forward in the system unless we put how much sliding scale insulin was given. -All MA's received a class on diabetic training and sliding scale insulin prior to working as a MA in the facility. -She thought audits were done on charts for missed medications and out of date medications but was not sure. -She did not know if eMAR audits had been completed. Interview with the Resident Care Coordinator (RCC) on 07/11/24 at 11:55am revealed: -She was not aware of sliding scale insulin being missed on the May, June, and July eMAR's for Resident #1. -She was not aware there were blanks on the eMAR where the sliding scale insulin should have been documented. -She thought she received a missed medication report but never saw areas where sliding scale insulin was missing or not recorded. -All MA's had diabetic training which included education on how to administer sliding scale insulin prior to starting on the medication carts. -She would occasionally audit FSBS to sliding scale insulin but not on a consistent basis.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 13 Interview with the Administrator on 07/11/24 at 12:30pm revealed: -She was not aware of sliding scale insulin being missed on the May, June, and July eMAR's for Resident #1. -She was not aware there were blanks on the eMAR where the sliding scale insulin should have been documented. -She and the RCC audited the charts monthly and had checked Resident #1's FSBS and sliding scale insulin to the orders. -She could not understand how the FSBS was there but no sliding scale insulin to cover it because she was told you could not finish the medication pass unless all blanks were checked off. Attempted telephone interview with Resident #1's PCP on 07/11/24 at 10:44am was unsuccessful.	D 367		