STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018040	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATAWBA VALLEY ASSISTED LIVING	4174 SHOOK ROAD CONOVER, NC 28613

(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 Catawba County DSS conducted an annual survey on March 04, 2025 - March 05, 2025.	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 ordered for 1 of 5 sampled residents (#1) related to a medication to lower blood sugar levels. The findings are: Review of Resident #1's current FL2 dated 03/12/24 revealed diagnoses included diabetes type 2. Review of Resident #1's Primary Care Provider's (PCP) order dated 10/08/24 revealed: -There was an order to check Resident #1's fingerstick blood sugar (FSBS) before each meal and at bedtime. -There was an order for humalog insulin (a medication to lower blood sugar levels) 10 units, inject before meals and at bedtime if Resident	D 358		

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D 358	Continued From page 1 #1's FSBS was greater than 130. Review of Resident #1's January 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check Resident #1's FSBS before meals and at bedtime. -There was an entry for humalog insulin, inject 10 units before meals and at bedtime at 7:30am, 11:30am, 4:30pm and 8:00pm, if Resident #1's FSBS was greater than 130. -There was documentation Resident #1's FSBS was 118 on 01/07/25 at 7:30am and she received 10 units of humalog insulin. -There was documentation Resident #1's FSBS was 129 on 01/13/25 at 8:00pm and she received 10 units of humalog insulin. -There was documentation Resident #1's FSBS was 122 on 01/17/25 at 7:30am and she received 10 units of humalog insulin. -There was documentation Resident #1's FSBS was 116 on 01/19/25 at 7:30am and she received 10 units of humalog insulin. -There was documentation Resident #1's FSBS was 128 on 01/21/25 at 7:30am and she received 10 units of humalog insulin. -There was documentation Resident #1's FSBS was 127 on 01/23/25 at 7:30am and she received 10 units of humalog insulin. -There was documentation Resident #1's FSBS was 123 on 01/31/25 at 4:30pm and she received 10 units of humalog insulin. -Resident #1's humalog insulin was administered 7 of 23 opportunities when her FSBS was 130 or less. Review of Resident #1's February 2025 eMAR revealed: -There was an entry to check Resident #1's FSBS before meals and at bedtime.	D 358		

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D 358	Continued From page 2 -There was an entry for humalog insulin, inject 10 units before meals and at bedtime at 7:30am, 11:30am, 4:30pm and 8:00pm, if Resident #1's FSBS was greater than 130. -There was documentation Resident #1's FSBS was 123 on 02/06/25 at 8:00pm and she received 10 units of humalog insulin. -There was documentation Resident #1's FSBS was 119 on 02/07/25 at 7:30am and she received 10 units of humalog insulin. -There was documentation Resident #1's FSBS was 102 on 02/09/25 at 7:30am and she received 10 units of humalog insulin. -There was documentation Resident #1's FSBS was 119 on 02/10/25 at 7:30am and she received 10 units of humalog insulin. -There was documentation Resident #1's FSBS was 94 on 02/22/25 at 8:00pm and she received 10 units of humalog insulin. -Resident #1's humalog insulin was administered 5 of 49 opportunities when her FSBS was 130 or less. Review of Resident #1's March 2025 eMAR revealed: -There was an entry to check Resident #1's FSBS before meals and at bedtime. -There was an entry for humalog insulin, inject 10 units before meals and at bedtime at 7:30am, 11:30am, 4:30pm and 8:00pm, if Resident #1's FSBS was greater than 130. -There was documentation Resident #1's FSBS was 120 on 03/01/25 at 4:30pm and she received 10 units of humalog insulin. -Resident #1's humalog insulin was administered 1 of 9 opportunities when her FSBS was 130 or less. Interview with Resident #1 on 03/05/25 at 11:10am revealed:	D 358		

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D 358	Continued From page 3 -She was on two different insulins, one long acting and one short acting. -She was always told what her FSBS was and how much insulin she was to receive when her FSBS was over 130. -She felt weak and sleepy when her blood sugar dropped but she did not feel like that often. -Her blood sugar stayed under 130 most of the time. Telephone interview with a representative from the facility's contracted pharmacy on 03/05/25 at 12:44pm revealed: -Resident #1 had a current order for humalog insulin, 10 units before meals and at bedtime if her FSBS was greater than 130. -If Resident #1 received humalog insulin, 10 units when her FSBS was less than 130 it could cause her blood sugar level to drop and she could experience symptoms such as sweating, headaches, shakiness and dizziness. Interview with a medication aide (MA) on 03/05/25 at 12:07pm revealed: -The MAs were responsible for checking Resident #1's FSBS before meals and at bedtime. -If Resident #1's FSBS was greater than 130 the MAs were responsible to administer humalog insulin 10 units to Resident #1. -She thought she incorrectly documented administering 10 units of humalog insulin to Resident #1 on 01/21/25 at 7:30am when the resident's FSBS was 128. -She did not know if any audits were done of residents' eMARs for medication administration accuracy. Telephone interview with Resident #1's PCP on 03/05/25 at 1:03pm revealed:	D 358		

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D 358	Continued From page 4 -He expected the MAs to not administer humalog insulin to Resident #1 when her FSBS was less than 130. -He was not aware Resident #1 had received 10 units of humalog insulin when her FSBS was 130 or less. -If Resident #1 received 10 units of humalog insulin when her FSBS was less than 130, she could experience symptoms of hypoglycemia (low blood sugar level), including light-headedness, altered mental status and diaphoresis (sweating). Interview with the Resident Care Director (RCD) on 03/05/25 at 12:16pm revealed: -The MAs were responsible to administer residents' medications according to the orders on the eMAR. -The MAs were responsible to document on the eMAR if a medication was held and the reason why it was held. -All MAs were trained on diabetic care and documentation upon hire by a contracted Registered Nurse (RN). -She was responsible for completing eMAR audits for accuracy. -The audits were being completed monthly but last week they were changed to being completed weekly. -She was not aware there were times Resident #1's humalog, 10 units was documented administered when her FSBS was less than 130. Interview with the Administrator on 03/05/25 at 12:18pm revealed: -The MAs were responsible for administering medications as ordered. -The RCD was responsible for completing weekly eMAR audits for accuracy. -MAs were trained upon hire on medication administration and proper documentation.	D 358		

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