STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 01/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF GARNE	1437 AVERSBORO ROAD GARNER, NC 27529

(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 Adult Care Licensure conducted a follow up survey on 1/13/15,1/15/15, and 1/16/15.	{D 000}		
{D 074}	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: The facility failed to assure walls,ceilings, and floors were kept in good repair for 4 of 9 common bathrooms (2 on South Hall, 1 on West Hall, and 1 on East Hall), and the carpeted floor of the front lobby. The findings are: Observation of the South Hall bathroom across from the hall phone on 1/15/15 at 2:40pm revealed: -Paint had worn away exposing metal above the toilet paper dispenser. -The bottom third of the wooden toilet stall had multiple pieces of wood missing exposing splintered unpainted wood. -Observation on 1/15/15 at 2:45pm of the other South Hall bathroom revealed multiple rusted areas on the metal toilet stall walls. Observation of the West 100 Hall on 1/15/15 at 2:50pm revelaed: -The sink countertop had a 2-3 inch area broken off area exposing wood underneath the sink.	{D 074}		

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{D 074}	Continued From page 1 Observation of the East Hall across from room #315 on 1/15/15 at 3pm revealed: -The bathtub had yellow and brown stains. -The bottom third of both sides of the entrance door had multiple areas of rough exposed wood. Observation of common bathrooms on 1/15/15 at 3:30pm revealed counter tops having exposed rough edges had been taped over. Observation of the front lobby on 1/15/15 at 4:40pm revealed there was a 4 foot long by 1 inch wide gap in the carpet 3 feet out from the wall underneath the fireplace. Observations throughout the survey(1/13/15, 1/15/15, and 1/16/15) revealed 2 housekeepers cleaning the common hall bathrooms as part of their daily routine and showers, bathtubs,and toilets were kept clean. Interview on 1/13/15 at 8:50am with the administrator revelaed: -Renovations on the facility's bathrooms had not started yet. -The owners had informed the Administrator that final plans had to be submitted to the town to get a permit to begin construction. Interview on 1/15/15 at 10am with the maintenance man revealed he had systematically gone around to the different bathrooms and replaced or repaired what he could. -He did not know why the remodel of the bathrooms had not started. -He was told bathroom floors, toilet stalls, and certain tiled areas would be replaced in the re-model.	{D 074}		

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{D 078}	10A NCAC 13F .0306(a)(5) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure that 2 of 9 common bathrooms were maintained free of all obstructions and hazards (1 on East Hall and 1 on West Hall). The findings are: Observation of the East Hall common bathroom across from room #315 on 1/15/15 at 3pm revealed: -An old metal heat vent attached to the wall under the window had exposed rough edges. -The sink counter top was loose from the wall and cracked. Observation of the West Hall Common bathroom closest to the TV room on 1/15/15 at 3:05pm revealed: -The far right toilet was covered with a black trash bag and the plumbing had been dismantled. -A trash bag twisted to resemble a rope was attached to each side of the toilet stall from one handicapped rail to the opposite handicapped rail.	{D 078}		

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{D 078}	Continued From page 3 A confidential resident interview revelaed: -"We shouldn't have to have broken down toilets in a place like this." -"They ought to fix this place up." -"There's no excuse for it." Interview with Administrator on 1/15/15 at 12 noon revealed: -The owner had been to the facility twice before Christmas and walked around to the different bathrooms and walked the facility. -Blueprints and floorplans of the facility were submitted to the town. -The Administrator was told the common bathroom's tubs, floors, and shower stalls were in the plans for the re-model. -The administrator believed the existing shower stalls would be replaced by tiled half stalls. -The owner had communicated to the administrator that there were plans to re-model the front lobby and make an activity room on the women's hall. -The owner had communicated to the administraotor that the dining room floors would be replaced in the future. A copy of a document titled "Contract" dated 11/25/14 between the owner and a contractor that was submitted to this surveyor by the end of the survey revealed: -The project was to begin 1/26/15. -The document was signed and dated by the facility's owner and contractor 11/25/14.	{D 078}		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs	D 273		

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D 273	Continued From page 4 of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify the physician of 1 of 3 sampled residents (#1) with Diabetes Mellitus regarding finger stick blood sugar (FSBS) results and insulin administration. The findings are: Resident #1's current FL-2 dated 11/20/14 revealed diagnoses included mild dementia, hypertension, chronic kidney disease stage 3, diastolic congested heart failure, gastro esophageal reflux disease and diabetes. The same FL-2 dated 11/20/14 revealed orders for the following: - Finger Stick Blood Sugar (FSBS) should be checked four times daily (before meals and at bedtime). - Novolog insulin (an insulin used to control high blood sugar) 100units (U)/milliliter (ml) vial is to be used with a sliding scale (0-189= 0 units; 190-219= 1 unit; 220-249= 2 units; 250-279= 3 units; 280-309= 4 units; 310-339= 5 units; 340-369= 6 units; 370-399= 7 units; less than 70 or greater than 450 call the physician). - No sliding scale insulin at bedtime. Review of doctor's orders written on 12/4/14 revealed: - Add additional parameter to sliding scale	D 273		

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D 273	Continued From page 5 Blood Sugar (BS) 400-450 give 8 units. - If BS greater than 450 always notify MD. Review of the "Blood-Sugar Monitoring Sliding Scale" form dated from 1/1/15-1/13/15 revealed: - Medication ordered and instructions for sliding scale: Novolog 0-189=0U, 190-219=1U, 220-249=2U, 250-279=3U, 280-309=4U, 310-339=5U, 340-369=6U, 370-399=7U, 400-450=8U and greater than 450 always notify MD. - The 7 a.m. finger sticks ranged from 79-268. - The 11 a.m. finger sticks ranged from 103-392. - The 4 p.m. finger sticks ranged from 90-343. - The 8 p.m. finger sticks ranged from 89-491. Review of the January 2015 Medication Administration Record (MAR) revealed: - Novolog 100units/ml vial insulin was to be used for the sliding scale. - If FSBS are between 0-189= 0, 190-219= 1U, 220-249=2U, 250-279= 3U, 280-309= 4U, 310-339=5U, 340-369=6U, 370-399=7U, 400-450=8U; Call Medical Doctor (MD) if less than 70 or greater than 450. - FSBS are to be done before each meal and at bedtime. - No sliding scale insulin to be given at bed time. - A line was drawn through the initial areas with the words "See Sheet" ("Blood-Sugar Monitoring Sliding Scale" form) for the amount of insulin administered. Review of the January 2015 "Blood-Sugar Monitoring Sliding Scale" form revealed insulin was administered without an order and the MD was not notified of 2 of 2 FSBS greater than 450;	D 273		

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D 273	Continued From page 6 - On 1/8/15 at 8 p.m., Resident #1's BS was 515. No documentation of MD having been notified. - On 1/12/15 at 8 p.m., Resident #1's BS was 491. Seven units of insulin were administered; no insulin ordered and no documentation of MD having been notified. Review of the "Blood-Sugar Monitoring Sliding Scale" form from 12/1/14-12/31/14 revealed: - The 7 a.m. finger sticks ranged from 58-297. - The 11 a.m. finger sticks ranged from 124-500. - The 4 p.m. finger sticks ranged from 101-500. - The 8 p.m. finger sticks ranged from 69-518. Review of doctor's orders written on 12/1/14 revealed for Blood Glucose (BG) 500 at lunch time BG check, give Novolog 10 units Subcutaneous (SQ) now and re-check BG in 30 minutes. Call the doctor ' s office for BG greater than 400. Documentation of Resident #1's December 2014 FSBS was on the "Blood-Sugar Monitoring Sliding Scale" form. Review of the December 2014 "Blood-Sugar Monitoring Sliding Scale" form revealed insulin was administered without an order 4 times and the MD was not notified of 2 of 2 FSBS less than 70 and 3 of 5 FSBS greater than 450. The following are examples: - On 12/3/14 at 11 a.m., Resident #1's BS was 500. Seven units of insulin was administered; no insulin ordered. No documentation of MD having	D 273		

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D 273	Continued From page 7 been notified. - On 12/12/14 at 7 a.m., Resident #1's BS was 58. Resident given orange juice. BS rechecked after breakfast and was 276. No documentation of MD having been notified of 58 BS. - On 12/16/14 at 8 p.m., Resident #1's BS was 69. No documentation of MD having been notified. - On 12/20/14 at 8 p.m., Resident #1's BS was 518. No documentation of MD having been notified. - On 12/29/14 at 11 a.m., Resident #1's BS was 485. No documentation of MD having been notified. Review of the "Blood-Sugar Monitoring Sliding Scale" form from 11/1/14-11/30/14 revealed: - The 7 a.m. finger sticks ranged from 67-345. - The 11 a.m. finger sticks ranged from 76-341. - The 4 p.m. finger sticks ranged from 61-567. - The 8 p.m. finger sticks ranged from 94-485. Review of provider's orders dated on 11/28/14 revealed to please administer 10 units of insulin. Documentation of Resident #1's November 2014 FSBS was on the "Blood-Sugar Monitoring Sliding Scale" form. Review of the November 2014 "Blood-Sugar Monitoring Sliding Scale" form revealed MD was not notified of 2 of 2 FSBS less than 70 and 3 of 5 FSBS greater than 450. The following are examples: - On 11/7/14 at 4 p.m., Resident #1's BS was 483. No documentation of MD having been notified. - On 11/8/14 at 8 p.m., Resident #1's BS was 485. No documentation of MD having been	D 273		

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D 273	Continued From page 8 notified. - On 11/17/14 at 8 p.m., Resident #1's BS was 476. No documentation of MD having been notified. - On 11/27/14 at 7 a.m., Resident #1's BS was 67. No documentation of MD having been notified. - On 11/30/14 at 4 p.m., Resident #1's BS was 61. No documentation of MD having been notified. Interview with Resident #1 on 1/16/15 at 8:38 a.m. revealed: - The resident was a diabetic. - When Resident #1's BS was low, she "almost gave out". - When Resident #1's BS was high, she just "feel bad and sleep". - Resident #1 noticed she had been given insulin twice sometimes when her BS was above 500, and the medication aide told her they had called the doctor. - She does not know how much insulin she had been given, but the medication aides said they had called the doctor. Interview with one of the Medication Aides (MA) on 1/13/15 at 3:20 p.m., who had administered insulin revealed: - On 11/28/14 at 4 p.m. she gave Resident #1 seven units of insulin for a BS of 497 because she thought the sliding scale said to give seven units. - On 11/28/14 at 4 p.m. she notified the MD of Resident #1's BS of 497 and was ordered to give the resident ten units of insulin. - On 11/28/14 at 4 p.m. she gave Resident #1 a total of seventeen units of insulin instead of ten units of insulin.	D 273		

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D 273	Continued From page 9 Interview with a second MA on 1/16/15 at 9:00 a.m., who also administered insulin revealed: - She called the doctor "depending" on the sliding scale. - On November 10th and 26th at 4 p.m. she misread the sliding scale and gave the 7 units. - She thought the "U" stood for "and up" instead of "units". Telephone interview with the Physician Assistant on 1/15/15 at 5:45 p.m. revealed: - It is her expectation that the facility notify her of any FSBS greater than 450 so that a decision can be made as to whether to send the resident out to the hospital or to give insulin. - The facility has called on different occasions for guidance and orders were given. - She does not expect insulin to be given without an order. Interview with the Resident Care Coordinator (RCC) on 1/16/15 at 9:15 a.m. revealed: - The RCC's expectation was that the medication aides follow orders as written and they can call the RCC "twenty four hours a day" and if the orders are still not understood, they can call the doctor together. - The medication aides should notify the MD for BS not covered by the sliding scale was the RCC's expectation. - There have not been any medication errors that the RCC was aware of. - The doctors see the blood sugars every week, so they review the MARs. - As far as she knows, "all" of the medication aides have had diabetic training. Interview with the Administrator on 1/16/15 at 9:25 a.m. revealed:	D 273		

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D 273	Continued From page 10 - She was not aware of any medication incident reports or medication errors. - If a resident was on a sliding scale, her expectation was for the medication aides to take the resident's blood sugar and give the insulin according to the sliding scale ordered by the provider. _____ The facility submitted a Plan of Protection dated 1/16/15 which revealed: - The staff will receive additional training to assure referral and follow up meet the routine and acute healthcare needs of residents as related to sliding scale insulin parameters. - The administrator, RCC or designee will conduct random chart audits, record reviews weekly x1 month then monthly thereafter to ensure the healthcare needs of residents are met according to above rule. - And as indicated on orders for sliding scale insulin, facility staff will contact MD for BS not within parameters. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 2, 2015.	D 273		
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	D 358		

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D 358	Continued From page 11 and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure the sliding scale insulin was administered as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (#1). The findings are: Resident #1's current FL-2 dated 11/20/14 revealed diagnoses included mild dementia, hypertension, chronic kidney disease stage 3, diastolic congested heart failure, gastro esophageal reflux disease and diabetes. The same FL-2 dated 11/20/14 revealed orders for the following: - Finger Stick Blood Sugar (FSBS) are to be checked four times daily (before meals and at bedtime). - Novolog insulin (used to control high blood sugar) 100units (U)/milliliter (ml) is to be used with a sliding scale (0-189= 0 units; 190-219= 1 unit; 220-249= 2 units; 250-279= 3 units; 280-309= 4 units; 310-339= 5 units; 340-369= 6 units; 370-399= 7 units; less than 70 or greater than 450 call the physician). - No sliding scale insulin at bedtime. Review of doctor's orders written on 12/4/14 revealed: - Add additional parameter to sliding scale Blood Sugar (BS) 400-450 give 8 units. - If BS greater than 450 always notify MD.	D 358		

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D 358	Continued From page 12 Review of the "Blood-Sugar Monitoring Sliding Scale" form dated from 1/1/15-1/13/15 revealed: - Medication ordered and instructions for sliding scale: Novolog 0-189=0U, 190-219=1U, 220-249=2U, 250-279=3U, 280-309=4U, 310-339=5U, 340-369=6U, 370-399=7U, 400-450=8U and greater than 450 always notify MD. - The 7 a.m. finger sticks ranged from 79-268. - The 11 a.m. finger sticks ranged from 103-392. - The 4 p.m. finger sticks ranged from 90-343. - The 8 p.m. finger sticks ranged from 89-491. Review of the January 2015 Medication Administration Record (MAR) revealed: - Novolog 100units/ml vial insulin was to be used for the sliding scale. - If FSBS are between 0-89= 0U, 190-219= 1U, 220-249=2U, 250-279= 3U, 280-309= 4U, 310-339=5U, 340-369=6U, 370-399=7U, 400-450=8U; Call Medical Doctor (MD) if less than 70 or greater than 450. - FSBS are to be done before each meal and at bedtime. - No sliding scale insulin to be given at bed time. - A line was drawn through the initial areas with the words "See Sheet" ("Blood-Sugar Monitoring Sliding Scale" form) for the amount of insulin administered. Documentation of Resident #1's FSBS for January 2015 was on the "Blood-Sugar Monitoring Sliding Scale" form. Review of the January 2015 "Blood-Sugar Monitoring Sliding Scale" form revealed insulin was administered without an order 6 times. The	D 358		

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NORTH POINTE ASSISTED LIVING OF GARNE	1437 AVERSBORO ROAD GARNER, NC 27529

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D 358	Continued From page 13 following are examples: - On 1/2/15 at 8 p.m., Resident #1's BS was 271. Three units of insulin were administered; no insulin ordered. - On 1/6/15 at 8 p.m., Resident #1's BS was 272. Three units of insulin were administered; no insulin ordered. - On 1/7/15 at 8 p.m., Resident #1's BS was 196. One unit of insulin was administered; no insulin ordered. - On 1/11/15 at 8 p.m., Resident #1's BS was 259. Three units of insulin were administered; no insulin ordered. - On 1/12/15 at 8 p.m., Resident #1's BS was 491. Seven units of insulin were administered; no insulin ordered. Review of the "Blood-Sugar Monitoring Sliding Scale" form from 12/1/14-12/31/14 revealed: - The 7 a.m. finger sticks ranged from 58-297. - The 11 a.m. finger sticks ranged from 124-500. - The 4 p.m. finger sticks ranged from 101-500. - The 8 p.m. finger sticks ranged from 69-518. Review of the December 2014 MAR revealed: - Novolog 100units/ml insulin was to be used for the sliding scale. - If FSBS are between 0-89= 0, 190-219= 1U, 220-249=2U, 250-279= 3U, 280-309= 4U, 310-339=5U, 340-369=6U, 370-399=7U; Call MD if less than 70 or greater than 450. - On 12/4/14 an "add on" of FSBS 400-450=8U. - FSBS are to be done before each meal and at bedtime. - No sliding scale insulin to be given at bed time.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 01/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF GARNE	1437 AVERSBORO ROAD GARNER, NC 27529

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D 358	Continued From page 14 - A line was drawn through the initial areas with the words "See Sheet" ("Blood-Sugar Monitoring Sliding Scale" form) for the amount of insulin administered. Review of doctor's orders written on 12/1/14 revealed for Blood Glucose (BG) 500 at lunch time BG check, give Novolog 10 units Subcutaneous (SQ) now and re-check BG in 30 minutes. Call the doctor's office for BG greater than 400. Documentation of Resident #1's FSBS for December 2014 was on the "Blood-Sugar Monitoring Sliding Scale" form. Review of the December 2014 "Blood-Sugar Monitoring Sliding Scale" form revealed insulin was administered without an order 4 times. The following are examples: - On 12/1/14 at 11 a.m., Resident #1's BS was 500. Seven units of insulin was administered; 10 units were ordered. - On 12/1/14 at 4 p.m., Resident #1's BS was 500. Seven units of insulin was administered; no insulin ordered. - On 12/3/14 at 11 a.m., Resident #1's BS was 500. Seven units of insulin was administered; no insulin ordered. - On 12/29/14 at 11 a.m., Resident #1's BS was 485. Eight units of insulin was documented as given; no insulin was ordered. Review of the "Blood-Sugar Monitoring Sliding Scale" form from 11/1/14-11/30/14 revealed: - The 7 a.m. finger sticks ranged from 67-345. - The 11 a.m. finger sticks ranged from 76-341. - The 4 p.m. finger sticks ranged from 61-567. - The 8 p.m. finger sticks ranged from 94-485.	D 358		

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D 358	Continued From page 15	D 358		

Review of the November 2014 MAR revealed:
- Novolog 100units/ml vial insulin was to be used for the sliding scale.
- If FSBS are between 0-89= 0U, 190-219= 1U, 220-249=2U, 250-279= 3U, 280-309= 4U, 310-339=5U, 340-369=6U, 370-399=7U; Call MD if less than 70 or greater than 450.
- FSBS are to be done before each meal and at bedtime.
- No sliding scale insulin to be given at bed time.
- A line was drawn through the initial areas with the words "See Sheet" ("Blood-Sugar Monitoring Sliding Scale" form) for the amount of insulin administered.
- Novolog 10 units subcutaneous was documented as administered as a one-time dose on 11/26/14 and 11/28/14.

Review of doctor's orders written on 11/28/14 revealed to please administer 10 units of insulin.

Documentation of Resident #1's FSBS November 2014 was on the "Blood-Sugar Monitoring Sliding Scale" form.

Review of the November 2014 "Blood-Sugar Monitoring Sliding Scale" form revealed insulin was administered without an order 4 times. The following are examples:
- On 11/7/14 at 4 p.m., Resident #1's BS was 483. Seven units of insulin was administered; no insulin ordered.
- On 11/10/14 at 4 p.m., Resident #1's BS was 567. Seven units of insulin was administered; no insulin ordered.
- On 11/17/14 at 8 p.m., Resident #1's BS was

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D 358	Continued From page 16 476. No documentation of MD having been notified. - On 11/26/14 at 4 p.m., Resident #1's BS was 446. Seven units of insulin was administered; no insulin ordered. - On 11/28/14 at 4 p.m., Resident #1's BS was 497. Seven units of insulin was administered; 10 units was ordered. Interview with Resident #1 on 1/16/15 at 8:38 a.m. revealed: - When Resident #1's BS was low, she "almost gave out". - When Resident #1's BS was high, she just "feel bad and sleep". - Resident #1 noticed she had been given insulin twice sometimes when her BS was above 500, but the medication aide told her they had called the doctor. - She does not know how much insulin she had been given, but the medication aides said they had called the doctor. Interview with one of the Medication Aides (MA) on 1/13/15 at 3:20 p.m., who had administered insulin revealed: - On 11/28/14 she gave Resident #1 seven units of insulin for a BS of 497 because she thought the sliding scale said to give seven units. - On 11/28/14 she notified the MD of Resident #1's BS of 497 and was ordered to give the resident ten units of insulin. - On 11/28/14 she gave the resident seventeen units of insulin. Interview with a second MA on 1/16/15 at 9:00 a.m., who also had administered insulin revealed: - She had taken care of and used Resident	D 358		

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D 358	Continued From page 17	D 358		

#1's sliding scale.
- "Whatever the paper says I go by that as the amount of insulin I have to give".
- She called the doctor "depending" on the sliding scale.
- In the month of November she misread the sliding scale and gave the 7 units.
- She thought the "U" stood for "and up" instead of "units".

Interview with a third MA on 1/16/15 at 10:18 a.m., who had administered insulin at bedtime revealed:
- She has been a medication aide for one year.
- She had taken care of and used Resident #1's sliding scale.
- She did not know Resident #1 was not supposed to get insulin at night.
- She just go by the MAR and the sliding scale.

Telephone interview with the Physician Assistant on 1/15/15 at 5:45 p.m. revealed:
- It is her expectation that the facility notify her of any FSBS greater than 450 so that a decision can be made as to whether to send the resident out to the hospital or to give insulin.
- The facility have called on different occasions for guidance and orders were given.
- She does not expect insulin to be given without an order.

Interview with the Resident Care Coordinator (RCC) on 1/16/15 at 9:15 a.m. revealed:
- The RCC's expectation was that the medication aides follow orders as written and they can call the RCC "twenty four hours a day" and if the orders are still not understood, they can call the doctor together.
- The medication aides should notify the MD

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D 358	Continued From page 18 for BS not covered by the sliding scale was the RCC's expectation. - There have not been any medication errors that the RCC was aware of. - She noticed "last night" sliding scale insulin was given at bed time without an order. - She may try to review the insulin MARs "monthly" and "occasionally" she may glance at them but she does not have a set system in place. - The doctors see the blood sugars every week, so they review the MARs. - As far as she knows, "all" of the medication aides have had diabetic training. - Soon there will be a staff meeting with all the medication aides and we will discuss "documentation, diabetes training, and making sure they do what is on the sliding scale". Interview with the Administrator on 1/16/15 at 9:25 a.m. revealed: - She was not aware of any medication incident reports or medication errors. - If a resident was on a sliding scale, her expectation was for the medication aides to take the resident's blood sugar and give the insulin according to the sliding scale ordered by the provider. - There is a "documentation" class scheduled in January 2015. The facility submitted a Plan of Protection dated 1/16/15 which revealed: - The RCC, administrator or designee will review sliding scale orders to ensure they are clarified with specific instruction. - The staff will receive additional training related to medication administration. - The administrator, RCC or designee will	D 358		

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D 358	Continued From page 19 review orders daily x 2 weeks, then weekly x 2 months and randomly thereafter to ensure orders are clarified. CORRECTION DATE FOR THE TYPE B VIOLATON SHALL NOT EXCEED MARCH 2, 2015	D 358		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: This rule is not met as evidenced by: Based on observation, interview, and record review;the facility failed to assure every resident received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration and referral and follow up. The findings are: 1.Based on observation , interview, and record review; the facility failed to assure sliding scale insulin was administered as ordered by a licensed prescribing practioner for 1 of 3 sampled residents (Resident #1) [Refer to Tag 035 Medication Administration.1004(a)(1) (Type B Violation).]	{D912}		

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{D912}	Continued From page 20 2.Based on observations, interviews, and record reviews, the facility failed to notify the physician of 1 of 3 sampled residents (#1) with Diabetes Mellitus regarding finger stick blood sugar (FSBS) results and insulin administration. [Refer to Tag 273 Health Care .0902(b) Type B Violation).]	{D912}		