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ROSEWOOD ASSISTED LIVING	3134 HARMONY HIGHWAY HARMONY, NC 28634

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on June 10, 2019 and June 11, 2019.	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 observations, interviews, and record review, the facility failed to administer medications as ordered by a physician for 2 of 2 sampled diabetic residents (Resident #3 and #6) related to administering insulin when fingerstick blood sugar readings were outside of parameters ordered by a physician. The findings are: 1. Review of Resident #3's current FL2 dated 05/28/19 revealed diagnoses included congestive	D 358		

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heart failure, diabetes, chronic kidney disease, and Chronic Obstructive Pulmonary Disease (COPD).

Review of Resident #3's record revealed:
-There was a hand written note dated 04/15/19 that Resident #3's blood sugar would not increase.
-FSBS was documented on note as 56 at 2:00pm, 51 at 3:00pm, 48 at 3:30pm and 55 at 4:00pm.
-There was a telephone order dated 04/15/19 received from the facility's contracted Nurse Practitioner (NP) to send Resident #3 to the local hospital for treatment and evaluation.

Review of Resident #3's Emergency Room (ER) Visit Summary dated 04/15/19 revealed:
-Resident #3 was evaluated in the ER for hypoglycemia (low blood sugar).
-The chief complaint for the ER visit was Resident #3 was "given scheduled insulin and has had blood sugars in the 40s."
-"Staff was unable to increase blood sugar."
-Resident #3 was administered oral glucose and intravenous fluids in the ER and blood sugar was documented at 176 at 6:00pm and 147 at 7:56pm.

a. Review of Resident #3's record revealed there was a physician's order for Novolog (a short acting insulin used to treat diabetes) inject 12 units subcutaneously with meals; hold if fingerstick blood sugar (FSBS) is <150.

Observation of Resident #3's medication on hand on 06/10/19 at 2:17pm revealed there was 1 partially used vial of Novolog available for administration dispensed on 05/23/19 and opened on 06/08/19.

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D 358	Continued From page 2 Review of Resident #3's April 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for Novolog inject 12 units subcutaneously 3 times daily with meals; hold for blood sugar less than 150 scheduled to be administered at 8:00am, 12:00pm, and 5:00pm. -Novolog was documented as administered 3 times daily from 04/01/19 to 04/30/19 except on 04/02/19 at 5:00pm, 04/05/19 at 12:00pm, 04/13/19 at 12:00pm and 5:00pm, 04/14/19 at 8:00am and 12:00pm, 04/15/19 at 5:00pm, 04/16/19 at 5:00pm, 04/17/19 at 8:00am and 12:00pm, 04/18/19 at 8:00am and 5:00pm, 04/24/19 at 5:00pm, 04/25/19 at 8:00am, 04/26/19 at 12:00pm, 04/29/19 at 12:00pm, and 04/30/19 at 12:00pm where it was documented medication was held due to physician's order or resident refused. -Novolog was documented as refused or withheld per physician orders for 18 of 90 opportunities from 04/01/19 to 04/30/19. -On 04/01/19 at 5:00pm, FSBS was documented as 112 and 12 units of Novolog was documented as administered. -On 04/15/19 at 8:00am, FSBS was documented as 134 and 12 units of Novolog was documented as administered. -On 04/15/19 at 12:00pm, FSBS was documented as 134 and 12 units of Novolog was documented as administered. -On 04/22/19 at 8:00am, FSBS was documented as 130 and 12 units of Novolog was documented as administered. -On 04/24/19 at 12:00pm, FSBS was documented as 140 and 12 units of Novolog was documented as administered.	D 358		

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Review of Resident #3's May 2019 eMAR revealed:
-There was a computer generated entry for Novolog inject 12 units subcutaneously 3 times daily with meals; hold for blood sugar less than 150 scheduled to be administered at 8:00am, 12:00pm, and 5:00pm.
-Novolog was documented as refused or withheld per physician orders for 28 out of 93 opportunities from 05/01/19 to 05/31/19.
-On 05/03/19 at 8:00am, FSBS was documented as 130 and 12 units of Novolog was documented as administered.
-On 05/07/19 at 8:00am, FSBS was documented as 134 and 12 units of Novolog was documented as administered.
-On 05/08/19 at 8:00am, FSBS was documented as 120 and 12 units of Novolog was documented as administered.
-On 05/28/19 at 8:00am, FSBS was documented as 120 and 12 units of Novolog was documented as administered.

Review of Resident #3's June 2019 eMAR revealed:
-There was a computer generated entry for Novolog inject 12 units subcutaneously 3 times daily with meals; hold for blood sugar less than 150 scheduled to be administered at 8:00am, 12:00pm, and 5:00pm.
-Novolog was documented as refused or withheld per physician orders for 7 out of 28 opportunities from 06/01/19 through 06/10/19.
-On 06/01/19, FSBS was documented as 121 at 8:00am and 133 at 5:00pm and 12 units of Novolog was documented as administered.

Interview with Resident #3 on 06/11/19 at 11:05am revealed:
-She remembered going to the hospital in April

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because her sugar was too low.
-She was confused when her blood sugar dropped.
-She had a stomach virus the weekend before the hospital visit.

Interview with the medication aide (MA) on 06/11/19 at 10:14am and 10:56am revealed:
-She had "probably missed the order to the hold the insulin" for Resident #3 when her FSBS was less than 150.
-She knew Resident #3 had an order for scheduled Novolog so she administered the medication.
-She did not remember being at the facility when Resident #3 was sent to the ER for her FSBS being low
-The MA on duty did not bring it to her attention.
-The MAs were responsible for faxing new physician's orders to the pharmacy.
-She or the other first shift MA would approve the orders once entered by the pharmacy.
-She or the other first shift MA would refer to the new medication order before they approved the order to appear on the eMAR.
-The Director was responsible for filing the order in the resident's chart.

Telephone interview with the facility's contracted Nurse Practitioner on 06/11/19 at 9:52am revealed:
-She did not know Resident #3 was receiving Novolog outside of the parameters in the physician's order.
-The facility was responsible for following physician's orders as written.
-Resident #3's FSBS was hard to control.
-The Novolog should have been held when Resident #3's FSBS was less than 150.
-The Novolog dose that was not held on 04/15/19

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D 358	Continued From page 5 could have led to Resident #3's ER visit on 04/15/19 for hypoglycemia. Interview with the Director on 06/11/19 at 10:40am revealed: -She remembered receiving the telephone order to send Resident #3 to the hospital on 04/15/19. -Resident #3's FSBS was low and the facility staff were not able to bring it up. -She did not know Resident #3's insulin order had parameters for administration based on the FSBS. -The MAs did not bring it to her attention that Resident #3 was administered Novolog when her FSBS was less than 150. -The MAs were responsible for following physician's orders as directed. -Resident #3's Novolog should not be administered if her FSBS was less than 150. -She or the MA's were responsible for faxing new physician's orders to the pharmacy to be processed. -The MA's were responsible for approving the physician's orders from the pharmacy to appear on the eMAR. -The MAs were responsible for double checking the eMAR before administration to make sure medications were administered accurately. -The facility did not have an audit procedure for eMAR's or physician's orders. Refer to the telephone interview with the Administrator on 06/11/19 at 12:45pm. b. Review of Resident #3's record revealed there was a physician's order dated 02/28/19 for Levemir (an insulin used to treat diabetes) inject 45 units subcutaneously twice daily; hold if fingerstick blood sugar (FSBS) is <150.	D 358		

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D 358	Continued From page 6 Observation of Resident #3's medication on hand on 06/10/19 at 2:17pm revealed there was 1 partially used vial of Levemir available for administration dispensed on 06/04/19 and opened on 06/08/19. Review of Resident #3's April 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for Levemir inject 45 units subcutaneously twice daily; hold if fingerstick blood sugar (FSBS) was <150 scheduled to be administered at 8:00am and 8:00pm. -Levemir was documented as administered twice daily from 04/01/19 to 04/30/19 except on 04/14/19 at 8:00am and 8:00pm, 04/15/19 at 8:00pm (when Resident #3 was at the hospital), 04/16/19 at 8:00pm, 04/17/19 at 8:00am and 8:00pm, and 04/25/19 at 8:00am where it was documented the resident refused or withheld per physician orders. -Levemir was documented as administered at 8:00am on 04/15/19 and 04/16/19. Review of Resident #3's May 2019 eMAR revealed: -There was a computer generated entry for Levemir inject 45 units subcutaneously twice daily; hold if fingerstick blood sugar (FSBS) was <150 scheduled to be administered at 8:00am and 8:00pm. -Levemir 45 units was documented twice daily from 05/01/19 to 05/15/19 at 8:00am except for 05/09/19 at 8:00am and 05/12/19 at 8:00am when the resident refused. -Levemir 45 units was documented as discontinued on 05/15/19. -There was a computer generated entry for Levemir inject 40 units subcutaneously twice	D 358		

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daily; hold if fingerstick blood sugar (FSBS) was <150 scheduled to be administered at 8:00am and 8:00pm.
-Levemir 40 units was documented as administered twice daily from 05/15/19 at 8:00pm to 05/31/19 except 05/19/19 and 05/20/19 at 8:00am, 05/24/19 at 8:00pm, 05/25/19 at 8:00am and 8:00pm, 05/26/19 at 8:00am and 8:00pm, and 05/30/19 at 8:00am where it was documented the resident refused or withheld per physician orders.

Review of Resident #3's June 2019 eMAR revealed:
-There was a computer generated entry for Levemir inject 40 units subcutaneously twice daily; hold if fingerstick blood sugar (FSBS) was <150 scheduled to be administered at 8:00am and 8:00pm.
-Levemir was documented as administered twice daily from 06/01/19 to 06/10/19.

Interview with Resident #3 on 06/11/19 at 11:05am revealed:
-She remembered going to the hospital in April because her sugar was too low.
-She was confused when her blood sugar dropped.
-She had a stomach virus the weekend before the hospital visit.

Interview with the medication aide (MA) on 06/11/19 at 10:14am and 10:56am revealed:
-She had probably missed the order to the hold the insulin for Resident #3 when her FSBS was less than 150.
-She knew Resident #3 had an order for scheduled Levemir so she administered the medication.
-She did not remember being at the facility when

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Resident #3 was sent to the ER for her FSBS being low
-The MA on duty did not bring it to her attention.
-The MAs were responsible for faxing new physician's orders to the pharmacy.
-She or the other first shift MA would approve the orders once entered by the pharmacy.
-She or the other first shift MA would refer to the new medication order before they approved the order to appear on the eMAR.
-The Director was responsible for filing the order in the resident's chart.

Telephone interview with the facility's contracted Nurse Practitioner on 06/11/19 at 9:52am revealed:
-She did not know Resident #3 was receiving Levemir outside of the parameters in the physician's order.
-The facility was responsible for following physician's orders as written.
-Resident #3's FSBS was hard to control.
-The Levemir should have been held when Resident #3's FSBS was less than 150.
-The Levemir dose that was not held on 04/15/19 could have led to Resident #3's ER visit on 04/15/19 for hypoglycemia.

Interview with the Director on 06/11/19 at 10:40am revealed:
-She remembered receiving the telephone order to send Resident #3 to the hospital on 04/15/19.
-Resident #3's FSBS was low and the facility staff was not able to bring it up.
-She did not know Resident #3's insulin order had parameters for administration based on the FSBS.
-The MAs did not bring it to her attention that Resident #3 was administered Levemir when her FSBS was less than 150.

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-The MAs were responsible for following physician's orders as directed.
-Resident #3's Levemir should not be administered if her FSBS was less than 150.
-She or the MA's were responsible for faxing new physician's orders to the pharmacy to be processed.
-The MA's were responsible for approving the physician's orders from the pharmacy to appear on the eMAR.
-The MAs were responsible for double checking the eMAR before administration to make sure medications were administered accurately.
-The facility did not have an audit procedure for eMAR's or physician's orders.

Refer to the telephone interview with the Administrator on 06/11/19 at 12:45pm.

2. Review of Resident #6's current FL2 dated 04/26/19 revealed:
-Diagnoses included congestive heart failure, diabetes and hypertension.
-Medications included Humalog (a short acting insulin used to treat diabetes) inject 20 units daily with breakfast, hold if Finger Stick Blood Sugar (FSBS) less than 100, Humalog inject 10 units daily at lunch, hold if FSBS less than 100, and Humalog insulin inject 12 units daily at dinner hold if FSBS less than 100.

a. Review of Resident #6's April 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer generated entry for Humalog inject 12 units subcutaneously daily at supper; hold for blood sugar less than 100 scheduled to be administered at 4:00pm.
-Humalog was documented as administered times daily from 04/01/19 to 04/30/19 except

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where it was documented medication was held due to physician's order or resident refused.
-On 04/01/19 at 4:00pm, FSBS was documented as 62 and 12 units of Humalog was documented as administered.

Review of Resident #6's May 2019 eMAR revealed:
-There was a computer generated entry for Humalog inject 12 units subcutaneously daily with supper; hold for blood sugar less than 100 scheduled to be administered at 4:00pm.
-On 05/30/19 at 4:00pm, FSBS was documented as 89 and 12 units of Humalog was documented as administered.

Review of Resident #6's June 2019 eMAR revealed:
-There was a computer generated entry for Humalog inject 12 units subcutaneously daily with supper; hold for blood sugar less than 100 scheduled to be administered at 4:00pm
-On 06/06/19, FSBS was documented as 94 at 4:00pm and 12 units of Humalog was documented as administered.

Observation of Resident #6's medication on hand on 06/10/19 at 2:17pm revealed there was 1 partially used vial of Humalog available for administration.

Interview with Resident #6 on 06/11/19 at 12:38pm revealed:
-The staff took her FSBS four times a day.
-Staff would tell her the FSBS, sometimes it was low.
-Staff would give her orange juice to drink.
-She knew when her blood sugar was low because she would feel dizzy and lightheaded.
-She never had any complications with her blood

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D 358	Continued From page 11 sugar being low. Interview with the medication aide (MA) on 06/11/19 at 11:20pm revealed: -She knew Resident #6 had an order for scheduled Humalog. -She had missed the order to the hold the insulin for Resident #4 when her FSBS was less than 100. -"There is a lot of resident always wanting their insulin and shots and sometimes it gets hectic." -"I guess I overlooked it." Interview with another MA on 06/11/19 at 12:20pm revealed: -She knew Resident #6 had parameters on the Humalog insulin to hold if FSBS less than 100. -She always compared the medications to the eMAR and then scanned the medication to the eMAR system. -She had been trained to use that system for a "double check" that the medication was the right meds and right time. -She was not aware the Humalog was administered to Resident #6 when the FSBS was below 100. -There was not current system in place to audit the eMAR or the medication carts. Telephone interview with the facility's contracted Nurse Practitioner on 06/11/19 at 9:52am revealed: -The facility was responsible for following physician's orders as written. -She did not know Resident #6 was receiving Humalog outside of the parameters in the physician's order. Interview with the Director on 06/11/19 at 10:40am revealed	D 358		

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-She did not know Resident #6's was administered Humalog insulin outside the parameters to hold if FSBS less than 100.
-The MAs did not bring it to her attention that Resident #6 was administered Humalog when her FSBS was less than 100.
-The MAs were responsible for following physician's orders as directed.
-The MAs were responsible for double checking the eMAR before administration to make sure medications were administered accurately.

Telephone interview with the facility's contracted Nurse Practitioner on 06/11/19 at 9:52am revealed the facility was responsible for following physician's orders as written.

Refer to the telephone interview with the Administrator on 06/11/19 at 12:45pm.

b. Review of Resident #6's current FL2 dated 04/26/19 revealed:
-Diagnoses included congestive heart failure, diabetes and hypertension.
-Medications included Levemir (an insulin used to treat diabetes) inject 80 units every morning hold if FSBS less than 150, Levemir insulin inject 20 units at bedtime hold if FSBS less than 150.

Review of Resident #6's April 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer generated entry for Levemir inject 80 units subcutaneously daily every morning; hold if fingerstick blood sugar (FSBS) was less than150 scheduled to be administered at 8:00am.
-There was a computer generated entry for Levemir inject 20 units subcutaneously daily at bedtime; hold if fingerstick blood sugar (FSBS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049004	A. BUILDING: _____ B. WING _____	R 06/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD ASSISTED LIVING	3134 HARMONY HIGHWAY HARMONY, NC 28634

(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
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was less than 150 scheduled to be administered at 8:00pm.
-On 04/06/19 at 8:00am, FSBS was documented as 122 and 80 units of Levemir was documented as administered.
-On 04/15/19 at 8:00am, FSBS was documented as 148 and 80 units of Levemir was documented as administered.
-On 04/27/19 at 8:00am, FSBS was documented as 143 and 80 units of Levemir was documented as administered.
-On 04/08/19 at 8:00pm, FSBS was documented as 125 and 20 units of Levemir was documented as administered.

Review of Resident #6's May 2019 eMAR revealed:
-There was a computer generated entry for Levemir inject 80 units subcutaneously daily every morning; hold if fingerstick blood sugar (FSBS) was less than150 scheduled to be administered at 8:00am.
-There was a computer generated entry for Levemir inject 20 units subcutaneously daily at bedtime; hold if fingerstick blood sugar (FSBS) was less than 150 scheduled to be administered at 8:00pm.
-On 04/01/19 at 8:00am, FSBS was documented as 145 and 80 units of Levemir was documented as administered.
-On 04/25/19 at 8:00am, FSBS was documented as 144 and 80 units of Levemir was documented as administered.
-On 04/08/19 at 8:00pm, FSBS was documented as 137 and 20 units of Levemir was documented as administered.

Review of Resident #6's June 2019 eMAR revealed:
-There was a computer generated entry for

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	HAL049004	A. BUILDING: _____ B. WING _____	R 06/11/2019

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ROSEWOOD ASSISTED LIVING	3134 HARMONY HIGHWAY HARMONY, NC 28634

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D 358	Continued From page 14 Levemir inject 80 units subcutaneously daily every morning; hold if fingerstick blood sugar (FSBS) was less than150 scheduled to be administered at 8:00am. -There was a computer generated entry for Levemir inject 20 units subcutaneously daily at bedtime; hold if fingerstick blood sugar (FSBS) was less than 150 scheduled to be administered at 8:00pm. -On 04/01/19 at 8:00am, FSBS was documented as 122 and 80 units of Levemir was documented as administered. -On 04/15/19 at 8:00am, FSBS was documented as 148 and 80 units of Levemir was documented as administered. -On 04/27/19 at 8:00am, FSBS was documented as 143 and 80 units of Levemir was documented as administered. -On 04/08/19 at 8:00pm, FSBS was documented as 125 and 20 units of Levemir was documented as administered. Observation of Resident #6's medication on hand on 06/10/19 at 2:17pm revealed there was 1 partially used vial of Levemir available for administration. Interview with Resident #6 on 06/11/19 at 12:38pm revealed: -She knew when her blood sugar was low because she would feel dizzy and lightheaded. -She never had any complications with her blood sugar being low. Interview with the medication aide (MA) on 06/11/19 at 11:20pm revealed: -She knew Resident #6 had an order for scheduled Levemir insulin hold if FSBS less than 150. -"There is a lot of residents always wanting their	D 358		

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insulin and shots and sometimes it gets hectic."
-"I guess I overlooked it."

Interview with another MA on 06/11/19 at 12:20pm revealed:
-She knew Resident #6 had parameters on the Levemir insulin to hold if FSBS less than 150.
-She always compared the medications to the eMAR and then scanned the medication to the eMAR system.
-She had been trained to use that system for a the "double check" to make sure the medication was the right meds and right time.
-There was not current system in place to audit the eMAR or the medication carts.

Telephone interview with the facility's contracted Nurse Practitioner on 06/11/19 at 9:52am revealed:
-The facility was responsible for following physician's orders as written.
-She did not know Resident #6 was receiving Levemir outside of the parameters in the physician's order.

Interview with the Director on 06/11/19 at 10:40am revealed
-She did not know Resident #6's was administered Levemir insulin outside the parameters to hold if FSBS less than 150.
-The MAs did not bring it to her attention that Resident #6 was administered Levemir insulin when her FSBS was less than 150.
-The MAs were responsible for following physician's orders as directed.
-The MAs were responsible for double checking the eMAR before administration to make sure medications were administered accurately.
-The facility did not have an audit procedure for eMAR's or physician's orders.

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D 358	Continued From page 16 Telephone interview with the facility's contracted Nurse Practitioner on 06/11/19 at 9:52am revealed the facility was responsible for following physician's orders as written. Refer to the telephone interview with the Administrator on 06/11/19 at 12:45pm. Telephone interview with the Administrator on 06/11/19 at 12:45pm revealed: -The Director was responsible for day to day operation of the facility. -She trusted the Director to make decisions related to the care of the residents. -She was available by telephone if the Director needed to contact her. The facility failed to assure insulin was administered as ordered for Resident #3 who was sent to the Emergency Room for a low blood sugar in the 40's due to administered insulin outside the parameters to hold if the blood sugar was below 150, and Resident #6 who had insulin administered outside the parameters to hold if blood sugar was less the 100. This failure was detrimental to the health, safety and welfare for the residents and constitutes a Type B violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 06/11/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 27, 2019.	D 358		

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D912	Continued From page 17	D912		
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: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to administering medication as ordered by a physician. The findings are: Based on observations, interviews, and record review, the facility failed to administer medications as ordered by a physician for 2 of 2 sampled diabetic residents (Resident #3 and #6) related to administering insulin when fingerstick blood sugar readings were outside of parameters ordered by a physician [Refer to Tag 358, 10A NCAC 13F 0.1004(a) Medication Administration (Type B Violation)].	D912		