Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018035	A. BUILDING: _____ B. WING _____	R 06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT VILLAGE AT NEWTON	1345 CHAPMAN LANE NEWTON, NC 28658

(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 along with a complaint investigation on 06/27/19 and 06/28/19.	D 000	**PLAN OF CORRECTION FOR TAG D212** Staffing Schedule immediately adjusted for In-House Census 1st Shift ~~1 PCA~~ 2 PCA 1 SIC 1Asst Admin - In Facility 9am-5pm 2nd Shift 2 PCA 1 SIC 500 Ft Person 3rd Shift 2 PCA 1 SIC 500 Ft Person	
D 212	10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors 10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors (a) On first and second shifts in facilities with a capacity or census of 31 or more residents and on third shift in facilities with a capacity or census of 91 or more residents, there shall be at least one supervisor of personal care aides, hereafter referred to as supervisor, on duty in the facility for less than 64 hours of aide duty per shift; two supervisors for 64 to less than 96 hours of aide duty per shift; and three supervisors for 96 to less than 128 hours of aide duty per shift. In facilities sprinklered for fire suppression with a capacity or census of 91 to 120 residents, the supervisor's time on third shift may be counted as required aide duty. (For staffing chart, see Rule .0606 of this Section.) This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure a supervisor of personal care aides was on duty in the facility on first and second shifts for 5 of 24 shifts sampled from 05/04/19 to 06/09/19 based on a census of 36 residents. The findings are:	D 212		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Georgette Johnson — **Administrator** — 7/22/19

STATE FORM 6899 MBKO11 If continuation sheet 1 of 23

Kimberly Duncan — **Admin Asst** — 7/22/19

Reviewed and Accepted 08/12/2019

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D 212	Continued From page 1 Review of the current facility census revealed a census of 36 residents. Observation of the Assistant Administrator on 06/28/19 at 12:45pm revealed she provided a list of four staff who were supervisors of PCAs. Review of staff time cards from 05/04/19 to 06/09/19 revealed: -On 05/18/19, on second shift, there was no supervisor on duty in the facility. -On 05/19/19, on second shift, there was no supervisor on duty in the facility. -On 06/01/19, on second shift, there was no supervisor on duty in the facility. -On 06/02/19, on second shift, there was no supervisor on duty in the facility. -On 06/09/19, on second shift, there was no supervisor on duty in the facility. Interview with the Assistant Administrator on 06/28/19 at 2:45pm revealed: -She was responsible for creating the staffing schedule and approving all schedule changes. -The facility's census was not less than 31 residents during the month of May 2019 or June 2019. -She lived within 500 feet of the facility so she thought she could be considered the supervisor on duty for first and second shift. -She did not know she had to be in the building during first and second shift to be counted as the supervisor on duty. -The Administrator was "always available by phone if needed but does not have a regular schedule for visiting the facility." Telephone interview with the Administrator on 06/28/19 at 3:43pm revealed: -The Assistant Administrator was responsible for	D 212		

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D 212	Continued From page 2 creating the staffing schedule. -She did not review the schedule. -She approved the staff time cards, but she did not know there was no supervisor on duty in the facility on all first and second shifts.	D 212		
D 219	10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 STAFFING CHART The following chart specifies the required aide, supervisory and management staffing for each eight-hour shift in facilities with a capacity or census of 21 or more residents according to Rules .0601, .0603, .0602, .0604 and .0605 of this Subchapter. Bed Count Position Type First Shift Second Shift Third Shift 21 - 30 Aide 16 16 8 Supervisor Not Required Not Required Not Required Administrator/SIC In the building, or within 500 feet and immediately available. 31-40 Aide 16 16 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 41-50 Aide 20 20 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 51-60 Aide 24 24 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 61-70 Aide 28 28 24 Supervisor 8* 8* 4 hours within the	D 219		

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D 219	Continued From page 3	D 219		

facility/4 hours within 500 feet and immediately available.**
Administrator On call
71-80 Aide 32 32 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
81-90 Aide 36 36 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
91-100 Aide 40 40 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
151-160 Aide 64 64 48

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D 219	Continued From page 4 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 161-170 Aide 68 68 48 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 171-180 Aide 72 72 48 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 181-190 Aide 76 76 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 191-200 Aide 80 80 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 201-210 Aide 84 84 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 211-220 Aide 88 88 64 Supervisor 16 16 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 221-230 Aide 92 92 64 Supervisor 16 16 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 231-240 Aide 96 96 64 Supervisor 24 24 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. This Rule is not met as evidenced by: Based on interviews and record review, the	D 219		

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D 219	Continued From page 5 facility failed to assure the required staffing hours were met on first and second shifts (7:00am-3:00pm and 3:00pm-11:00pm) for 10 of 24 weekend shifts sampled from 05/04/19 to 06/09/19 based on a census of 36 residents. The findings are: Review of the current facility census a census of 36 residents. Review of staff time cards for first and second weekend shifts from 05/04/19 through 06/09/19 revealed: -On 05/04/19, on first shift, there was a total of 12 hours of aide coverage with a shortage of 4 hours. -On 05/04/19, on second shift, there was a total of 12 hours of aide coverage with a shortage of 4 hours. -On 05/05/19, on first shift, there was a total of 12 hours of aide coverage with a shortage of 4 hours. -On 05/05/19, on second shift, there was a total of 12 hours of aide coverage with a shortage of 4 hours. -On 05/18/19, on first shift, there was a total of 12 hours of aide coverage with a shortage of 4 hours. -On 05/18/19, on second shift, there was a total of 13 hours of aide coverage with a shortage of 3 hours. -On 05/19/19, on first shift, there was a total of 13 hours of aide coverage with a shortage of 3 hours. -On 06/02/19, on first shift, there was a total of 12 hours of aide coverage with a shortage of 4 hours. -On 06/08/19, on first shift, there was a total of 8 hours of aide coverage with a shortage of 8	D 219		

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D 219	Continued From page 6 hours. -On 06/09/19, on second shift, there was a total of 12 hours of aide coverage with a shortage of 4 hours. Confidential interview with three staff revealed: -"Sometimes we are short staffed on the weekends". -It was hard to get everything done on the weekends when only one medication aide (MA)/supervisor and one personal care aide (PCA) were working with a census of 36 residents. -Staff complained to management but were told they were looking for more help. -Staff worked several months with only one MA and one PCA on the weekends. -"I have trouble getting to everyone's shower on the weekend." -None of the residents go to the day-programs on the weekend and it gets "very hectic around here". -It was hard to provide good care when there was not have enough staff. -There should be a ratio to how many staff should work with 36 residents. Confidential telephone interview with a resident's family member revealed: -The family member visited the facility at least weekly. -The family member had noticed that the "staff were stretched" during his visits. -The family member was afraid the facility may not be able to meet the needs of the resident because more assistance was needed. -The resident was needing help with feedings and transfers. Interview with the Assistant Administrator on	D 219		

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D 219	Continued From page 7 06/28/19 at 2:45pm revealed: -She was responsible for creating the staff work schedule and approving all changes to the schedule. -The facility's census was not less than 31 residents during the month of May 2019 or June 2019. -She lived within 500 feet of the facility, was "in and out of the facility" during the day, but she did not complete a time card. -She thought her hours in the facility could be counted toward the total hours of aide coverage. -The Administrator was "always available by phone if needed but did not have a regular schedule for visiting the facility." Telephone interview with the Administrator on 06/28/19 at 3:43pm revealed: -The Assistant Administrator was responsible for creating the staffing schedule and assuring staffing requirements were met. -She did not review the schedule. -She approved the staff time cards, but she did not realize the hours of aide coverage were insufficient.	D 219		
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 of residents.	D 273		

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D 273	Continued From page 8 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify 1 of 3 sampled residents (Resident #6) licensed prescribing practitioner in regards to fingerstick blood sugars (FSBS) below 65. The findings are: Review on 06/27/19 of the facility Diabetic Protocol revealed: -"Blood sugar less than 65: If a resident is unresponsive and unable to swallow immediately call 911 and initiate emergency response with EMS. If resident is responsive and able to safely swallow call MD and hold insulin (if he/she receive it). Give 2 tablespoons of sugar with 8 ounces of orange juice and encourage resident to eat a small snack. Re-check blood sugar in 30 minutes if still less than 60 repeats with 2 tablespoons of sugar with 8 ounces of orange juice and call physician and notify EMS to evaluate further." Review of Resident #6's current FL2 dated 02/13/19 revealed: -Diagnoses included schizoaffective disorder, anxiety and diabetes. -There was an order for FSBS checks four times a day with meals and at bedtime. -There was an order for Novolog (a fast-acting insulin) inject 32 units subcutaneous (SQ) before meals. -There was an order for Tresiba (a daily long acting maintenance insulin) inject 85 units SQ at bedtime. -There was an order to "Hold insulin" if FSBS was	D 273	**PLAN OF CORRECTION FOR TAG D 273** **Page 8- Page 14** MD/NP immediately contacted for clarification. Med Techs immediately inservice by Corp RN on contacting MD for FSBS under 60. AA/RCD will review all FSBS results daily to ensure proper S/S insulin is given, and Physician was notified of Hi/ Low results Corp RN will follow up X3 monthly to review results Corp Admin will follow up X3 monthly to review results	8/13/19

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D 273	Continued From page 9 lower than 80. Review of Resident #6's April 2019 Medication Administration Record (MAR) revealed documentation dated 04/08/19 at 5:00pm "Held Novolog" FSBS 36 EMS called. Review of Resident #6's April 2019 Medication Administration Record (MAR) revealed: -On 04/08/19 at 4:00pm the FSBS was documented as 36; there was documentation Novolog was held, Emergency Medical Services was called. -On 04/10/19 at 4:00pm the FSBS was documented as 51, and on 04/17/19 the FSBS was documented as 59. -On 04/05/19 at 8:00pm the FSBS was documented as 48. -On 04/13/19 at 8:00pm the FSBS was documented as 58. -On 04/16/19 at 8:00pm the FSBS was documented 54. -On 04/25/19 at 8:00pm the FSBS was documented as 61. -On 04/30/19 at 8:00pm the FSBS was documented as 59. -There was documentation Novolog 32 units was held on 04/23/19 FSBS=54 and on 04/24/19 FSBS=61. -There was no documentation the licensed practitioner was notified of any of the low blood sugars below 65 per the facility policy. Review of Resident #6's May 2019 MAR revealed: -On 05/08/19 at 4:00pm the FSBS was documented as 63. -On 05/03/19 at 8:00pm the FSBS was documented as 49. -On 05/06/19 at 8:00pm the FSBS was	D 273		

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D 273	Continued From page 10 documented as 61. -On 05/13/19 at 8:00pm the FSBS was documented as 54. -On 05/20/19 at 8:00pm the FSBS was documented as 62. -There was no documentation the licensed practitioner was notified of the low blood sugars below 65 per the facility policy. Review of Resident #6's June 2019 MAR revealed: -On 06/01/19 at 4:00pm the FSBS was documented as 49. -On 06/11/19 at 4:00pm the FSBS was documented as 59. -On 06/19/19 at 4:00pm the FSBS was documented as 61. -On 06/04/19 at 8:00pm the FSBS was documented as 63. -On 06/07/19 at 8:00pm the FSBS was documented 54. -On 06/08/19 at 8:00pm the FSBS was documented as 59. -On 06/09/19 at 8:00pm the FSBS was documented as 47. -There was no documentation the licensed practitioner had been notified of the low blood sugars below 65 per the facility policy. Telephone interview on 06/28/19 at 11:15am with Resident #6's licensed practitioner revealed: -She could not recall the facility contacting her with the low FSBS for Resident #6 during the months on April, May and June 2019. -She would like to have known Resident #6 had low FSBS in the 40's and 50's so she could have adjusted the Novolog insulin. -She was the facility every other week and usually reviewed the current MARs for the month but did not regularly review the MAR for the previous	D 273		

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D 273	Continued From page 11 months. -She expected the facility staff to call her if Resident #6's FSBS were less than 60 and to send to the hospital if Resident #6's FSBS was 50 or below. -"The facility forgets it is just as important to call me with low blood sugar as it is with high blood sugar." -She could not recall the facility contacting her regarding Resident #6's FSBS 36 on 04/08/19 or that EMS had come to the facility that day to treat Resident #6's blood sugar of 36. -She thought the facility had a policy on diabetes and low FSBS. Interview on 06/28/19 at 2:00pm with Resident #6 revealed: -Staff obtained his FSBS four times daily and would tell him his FSBS results. -He could tell when his FSBS was low because he would feel "Lightheaded." -His FSBS were low at times and staff would give him orange juice and a snack. -He had not been in the hospital during the last six months, but EMS came in April 2019 for his low blood sugar. Interview on 06/28/19 at 1:10pm with a medication aide (MA) revealed: -The facility policy for FSBS was if the blood sugar was 65 or below the licensed practitioner was to be notified and the insulin was not to be given. -Resident #6 had low blood sugars at times, but staff would give him orange juice and a snack then Resident #6's blood sugar would easily come up. -She could not recall Resident #6 having low blood sugars on her shift and had never contacted the licensed practitioner about low	D 273		

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D 273	Continued From page 12 blood sugars for Resident #6. Interview on 06/28/19 at 3:15pm with another MA revealed: -She could not recall the facility policy on diabetes but thought the physician would be called if a FSBS was 50 or lower. -She had never contacted the licensed practitioner for low blood sugars for Resident #6. Review of Resident #6's progress notes revealed there was no documentation the licensed practitioner was called for any of the FSBS below 65 during the month of April, May or June 2019. Interview on 06/28/19 at 2:15pm with the Assistant Administrator (AA) revealed: -She knew the facility policy was to hold the insulin and to contact the physician when the resident's FSBS was below 65. -She did not know Resident #6's FSBS were below 65 and the licensed practitioner was not contacted per the facility policy. -The MA/ Supervisor who worked during the week was responsible for communicating with the resident's physicians. -She knew Resident #6 had a low FSBS on 04/08/19 of 36 and EMS was contacted. -EMS had initiated intravenous therapy and Resident #6's blood sugar came up. Resident #6 never left the facility. -She thought the licensed practitioner was notified concerning Resident #6's low blood sugar on 04/08/19 and the EMS visit. -She relied on the MAs to contact the resident's physician for blood sugars that were lower than 65 and to document the call in the progress notes. -The second shift MAs were new to the facility, "they definitely need more diabetic training."	D 273		

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D 273	Continued From page 13 Telephone interview on 06/28/19 3:28pm with the Administrator revealed: -She did not know Resident #6's licensed practitioner was not called in regards to the low blood sugars below 65 per the facility policy. -She expected the MAs to follow the facility policy on diabetic care and hold the insulin and contact the licensed practitioner for FSBS lower than 65. -She relied on the AA to handle all day to day operations in the facility. The failure of the facility to assure referral and follow up to the licensed practitioner for Resident #6 who had been treated with IV glucose by EMS in April 2019 and had low FSBS 8 times in April 2019, 5 times in May 2019 and 7 times in June 2019 placing Resident #6 at risk for hypoglycemia. This failure was detrimental to the health, safety and welfare for Resident #6's and constitutes a Type B violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 05/31/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 14, 2019.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from	D 282		

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D 282	Continued From page 14 contamination. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination related to build-up of a black substance in the ice machine, food storage on the floor in the dry storage room, dirty floor in the dry storage room, food items stored in the dry storage room that was opened but not closed properly, a greasy film across the front of the oven and toaster, and food service trays with peeling surfaces. The findings are: Review of the local Environmental Health sanitation report dated 04/08/19 revealed: -An inspection score of 95. -One demerit was issued for "Food-Contact Surfaces-Cleanability" with instructions to replace worn trays. Observation of the kitchen and kitchen storage areas on 06/27/19 at 9:58am revealed: -There was a build-up of a black substance on the interior wall of the ice machine. -An unopened large bag of sugar lying on the floor between two of the rolling food storage shelves. -Food crumbs, dried spaghetti, small pieces of cereal and a funnel were observed on the floor under the food storage racks in the dry storage room. -Food items including a bag of cornmeal and a package of blueberry muffins that had been opened but not dated or sealed for reuse properly.	D 282	Dietary Staff immediately cleaned Dietary Staff immediately put sugar in a cover container Dietary Staff immediately cleaned Dietary Staff immediately put a cover container	6/27/19 6/27/19 6/27/19 6/27/19

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D 282	Continued From page 15 -A black and brown greasy film covered the front of the oven and a greasy film covered the front of the toaster. -Food service trays had an exterior coating that was peeling off the top and sides of the trays. Interview with the part-time cook on 06/28/19 at 9:45am revealed: -Open foods should be covered, and she was not aware that the blueberry muffins were opened. -The kitchen area was cleaned and mopped daily but she had never cleaned the dry storage room or the ice maker. -The sugar was on the floor because it was very heavy to lift and pour into the storage container. -They had some newer food serving trays but there were still many of the older serving trays being used at each meal because there were not enough newer food trays for all the residents. -The cook only had from 6:30am to 9:00am to prepare, serve and clean up after breakfast, from 10:00am to 1:30pm to prepare, serve and clean-up after lunch, and from 3:30pm to 6:30pm to prepare, serve and clean-up after dinner. - "I do the best I can with the time I have" and that there was no extra time to do any deep cleaning. Interview with the Assistant Administrator on 06/28/19 at 1:50pm revealed: -The staff normally did not store any food items on the floor. -She did an inventory of the dry food storage on 06/26/19 and the cornbread mix and blueberry muffins were not open at that time. -They had been having problems with the ice machine and it was going to be serviced. -She was not aware of the serving trays being in poor condition. -They did not have a checklist of cleaning items including the floors, equipment and ice machine.	D 282	Dietary Staff immediately cleaned Dietary Staff immediately ordered New Food Trays	6/27/19 6/27/19

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D 282	Continued From page 16 but they needed to create one. -The cook is responsible for assuring the food is prepared and served, and the kitchen cleaned afterward in preparation for the next meal. Telephone interview with the Administrator on 06/28/19 at 3:46pm revealed: -She relied on the Assistant Administrator for the daily operations of the facility. -She was unaware of the concerns identified during the kitchen and kitchen storage areas observations.	D 282	**PLAN OF CORRECTION FOR TAG D 282** **Page 14- Page23** Immediately Asst Admin will provide Dietary Staff with a cleaning daily schedule Asst Admin will check Kitchen daily after each meals and at the end of the day.	7/1/19
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 records, the facility failed to administer medications as ordered by a licensed prescribing	D 358	Asst Admin inservice all Kitchen staff on storage of foods and cleaniness of kitchen.	

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D 358	Continued From page 17 practitioner for 1 of 3 sampled residents (Resident #6), related to administering insulin outside of the ordered parameters. The findings are: Review of Resident #6's current FL2 dated 02/13/19 revealed: -Diagnoses included schizoaffective disorder, anxiety and diabetes. -There was an order for FSBS checks four times a day with meals and at bedtime. -There was an order for Novolog (a fast-acting insulin) inject 32 units subcutaneous (SQ) before meals. -There was an order to "Hold insulin" for FSBS lower than 80. Review of Resident #6's April 2019 Medication Administration Record (MAR) revealed: -There was an entry for FSBS checks three times a day with meals scheduled at 7:00am, 11:30am, and 4:00pm. -There was an entry to administer 32 units of Novolog insulin three times daily with meals. -There was an entry to hold Novolog insulin if FSBS was below 80. -The 7:00am FSBS range was 109-330. -The 11:30am FSBS range was 66-409. -On 04/06/19 at 11:30am the FSBS results was documented as 66, there was documentation 32 units of Novolog was administered. -The 4:00pm FSBS range was 36-357. -On 04/02/19 at 4:00pm the FSBS was documented as 70; Novolog 32 units was documented as administered. -On 04/08/19 at 4:00pm the FSBS was documentation as 36; there was documentation Novolog was held, Emergency Medical Services was called.	D 358	**FOR TAG D 273** **Page 17- Page 22** MD/NP immediately contacted for clarification. Med Techs immediately inservice by Corp RN on contacting MD for FSBS under 60. AA/RCD will review all FSBS results daily to ensure proper S/S insulin is given, and Physician was notified of Hi/Low results Corp RN will follow up X3 monthly to review results Corp Admin will follow up X3 monthly to review results	8/13/19

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D 358	Continued From page 18 -On 04/10/19 at 4:00pm the FSBS was documented as 51; Novolog 32 units was documented as administered. -On 04/17/19 at 4:00pm the FSBS was documented as 59; Novolog 32 units was documented as administered. -On 04/18/19 at 4:00pm the FSBS was documented as 68; Novolog 32 units was documented as administered. -On 04/30/19 at 4:00pm the FSBS was documented as 77; Novolog 32 units was documented as administered. -There was no other documentation Novolog 32 units was held as ordered for FSBS lower than 80 on the April 2019 MAR. Review of Resident #6's record revealed a signed physician's order dated 05/20/19 stop current Novolog order and start Novolog 30 units before breakfast and 25 units at lunch and supper. Review of Resident #6's May 2019 MAR revealed: -There was an entry for FSBS checks three times a day with meals scheduled at 7:00am, 11:30am, and 4:00pm. -There was an entry to administer 32 units of Novolog insulin three times daily with meals. -There was an entry to hold Novolog insulin if FSBS was below 80. -There was a handwritten entry to discontinue Novolog 32 units "order changed" dated 05/15/19 on the MAR. -There was a handwritten entry dated 05/15/19 "see new order" Novolog administer 25 units SQ three times daily prior to meals. -There was a handwritten entry on 05/21/19 to administer Novolog 30 units before breakfast and administer 25 units before lunch and supper. -The 7:00am FSBS range was 108-322.	D 358		

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D 358	Continued From page 19 -The 11:30am FSBS range was 90-380. -The 4:00pm FSBS range was 54- 310. -On 05/04/19 at 4:00pm the FSBS was documented as 69; Novolog 32 units was documented as administered. -On 05/08/19 at 4:00pm the FSBS was documented as 63; Novolog 32 units was documented as administered. -On 05/15/19 at 4:00pm the FSBS was documented as 77; Novolog 32 units was documented as administered. -On 05/22/19 at 4:00pm the FSBS was documented as 67; Novolog 25 units was documented as administered. -There was no other documentation Novolog insulin was held as ordered for FSBS lower than 80 on the May 2019 MAR. Telephone interview on 06/28/19 at 11:15 am with Resident #6's prescribing licensed practitioner revealed: -She did not know staff had administered insulin outside the ordered perimeters during the months of April and May 2019. -She would liked to have known Resident #6 had low FSBS in the 40's and 50's so she could had adjusted the Novolog insulin. -She was in the facility every other week and usually reviewed the MARs for the current month but did not regularly review the MARs for the previous months. -She expected the facility staff to follow her order and to hold the Novolog if Resident #6's FSBS was lower then 80. Interview on 06/28/19 at 2:00pm with Resident #6 revealed: -Staff obtained his FSBS four times daily and would tell him his FSBS results. -He could tell when his FSBS was low because	D 358		

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D 358	Continued From page 20	D 358		

he would feel 'Lightheaded."
-His FSBS were low at times and staff would give him orange juice and a snack.
-He had a snack ever night at 8:00pm.

Interview on 06/28/19 at 1:10pm with a medication aide (MA) revealed:
-She knew Resident #6's had orders to hold Novolog if his FSBS was less than 80.
-Resident #6 had low blood sugars at times, but with orange juice and a snack the blood sugar easily came up.
-She could not recall Resident #6 having low blood sugars on her shift.
-She was not aware who reviewed the MARs monthly for missed medications or incorrect medications administered.

Interview on 06/28/19 at 3:15pm with another MA revealed:
-She knew Resident #6 had orders to hold Novolog if his FSBS was below 80.
-"Sometimes it is very hectic around here, "Maybe I did give the insulin when [Resident#6] blood sugar was low."

Interview on 06/28/19 at 2:15pm with the Assistant Administrator (AA) revealed:
-She did not know staff were administering insulin outside the ordered perimeters, if the FSBS below 80 hold Novolog.
-There was no current system in place for reviewing MARs monthly for incorrect doses of medications.
-The MA/ Supervisor were responsible for communicating with the physicians.

Telephone interview on 06/28/19 3:2 with the Administrator revealed:
-She was unaware the MAs were administering

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D 358	Continued From page 21 insulin to Resident #6 with blood sugars lower than 80. -She expected the MA to follow the prescribing licensed practitioners orders, and hold the insulin if Resident #6's FSBS was below 80. -She relied on the AA to handle all day to day operations in the facility.	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: 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 not notifying a resident's medical provider for low fingerstick blood sugar readings. The findings are: Based on observations, interviews, and record reviews, the facility failed to notify 1 of 3 sampled residents (Resident #6) licensed prescribing practitioner in regards to fingerstick blood sugars (FSBS) below 65. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care Referral and Follow Up	D912	**PLAN OF CORRECTION FOR TAG D 912** All staff in-service with Corp Admin on Resident Rights	7/22/19

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D912	Continued From page 22 (Type B Violation)].	D912		