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
	HAL010007	A. BUILDING: _____ B. WING _____	R-C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LELAND HOUSE	1935 LINCOLN ROAD LELAND, NC 28451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Brunswick County Department of Social Services conducted a follow up survey from 11/19/19 - 11/21/19.	{D 000}		
{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. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION. The Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION The facility failed to assure the acute and chronic health care needs were met for 2 of 5 sampled residents (#1, #2) related to failure to notify the endocrinologist of elevated finger stick blood sugar (FSBS) results outside of ordered parameters (#2) and delays is notification for FSBS results outside of ordered parameters (#1, #2). The findings are:	{D 273}		

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{D 273}	Continued From page 1 1. Review of Resident #2's current FL-2 dated 9/23/19 revealed diagnoses included diabetes mellitus type II, anxiety, essential hypertension, Vitamin B deficiency, osteoarthritis, atherosclerotic heart disease, and coronary artery without angina pectoris. Review of Resident #2's physiioan's orders dated 10/28/19 revealed there was a medication order for Novolog sliding scale insulin (SSI) inject subcutaneously (SQ) three times daily before meals according to the following scale: if finger stick blood sugar (FSBS) is less than (<) 70, call MD; for FSBS <150=0 units; for FSBS result of 150-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; 401-450=12 units; >450=Call endocrinology. Review of Resident #2's electronic Medication Administration Record (eMAR) dated September 2019 revealed: -There was an entry for Novolog SSI: If blood sugar is less than 70, call MD; if blood sugar is 150 to 200, give 2 Units; if blood sugar is 201 to 250, give 4 Units; if blood sugar is 251 to 300, give 6 Units; if blood sugar is 301 to 350, give 8 Units; if blood sugar is 351 to 400, give 10 Units; if blood sugar is 401 to 450, give 12 Units; if blood sugar is greater than 450, call endocrinology with a start date documented as 08/19/19. -On 09/26/19 at 5:00pm, Resident #2's FSBS was documented as 556; there was no documentation the endocrinologist was notified. -On 09/27/19 at 7:30am, her FSBS was documented as 502; there was no documentation the endocrinologist was notified. -On 09/29/19 at 7:30am, her FSBS was documented as 569; there was no documentation the endocrinologist was notified.	{D 273}		

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{D 273}	Continued From page 2 Review of Resident #2's October 2019 eMAR revealed: -There was an entry for Novolog SSI: If blood sugar is less than 70, call MD; if blood sugar is 150 to 200, give 2 Units; if blood sugar is 201 to 250, give 4 Units; if blood sugar is 251 to 300, give 6 Units; if blood sugar is 301 to 350, give 8 Units; if blood sugar is 351 to 400, give 10 Units; if blood sugar is 401 to 450, give 12 Units; if blood sugar is greater than 450, call endocrinology with a start date documented as 08/19/19. -On 10/26/19 at 7:30am, Resident #2's FSBS was documented as 467; there was no documentation the endocrinologist was notified. Review of Resident #2's November 2019 eMAR revealed: -There was an entry for Novolog SSI: If blood sugar is less than 70, call MD; if blood sugar is 150 to 200, give 2 Units; if blood sugar is 201 to 250, give 4 Units; if blood sugar is 251 to 300, give 6 Units; if blood sugar is 301 to 350, give 8 Units; if blood sugar is 351 to 400, give 10 Units; if blood sugar is 401 to 450, give 12 Units; if blood sugar is greater than 450, call endocrinology with a start date documented as 08/19/19. -On 11/03/19 at 5:00pm, Resident #2's FSBS result was documented as "High;" there was no documentation the endocrinologist was notified. -On 11/18/19 at 7:30am, her FSBS result was documented as 455; there was no documentation the endocrinologist was notified. -On 11/18/19 at 5:00pm, her FSBS result was documented as "High;" there was no documentation the endocrinologist was notified. Review of Resident #2's Progress Notes dated	{D 273}		

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{D 273}	Continued From page 3 from 09/19/19-11/21/19 revealed: -There was no documentation the endocrinologist was notified of Resident's #2's FSBS results above the ordered parameters on the following days: 09/26/19- 556; 09/27/19- 502; 09/29/19- 569; 10/26/19- 467; 11/03/19- "High"; 11/18/19- 455; and 11/18/19- "High." -There was documentation dated 11/19/19 at 10:36am that Resident #2 had a blood sugar of 524 and the medication aide (MA) contacted the endocrinologist about the FSBS result. Interview with MA on 11/21/19 at 2:34pm revealed: -She remembered calling Resident #2's primary care provider (PCP) related to the Resident #2's FSBS result of High on 11/03/19 at 5:00pm. -She did not follow through with her documentation of notifying the PCP in the resident's progress notes. -She did not notify the endocrinologist, as ordered. Interview with another MA on 11/21/19 at 3:06pm revealed she "forgot" to notify the endocrinologist or PCP about Resident #2's elevated FSBS of 455 on 11/21/19 at 7:30am. Interview with the Director of Resident Care (DRC) on 11/21/19 at 3:25pm revealed: -Her expectation was Resident #2's endocrinologist should have been contacted for a FSBS result of 455 on 11/18/19 at 7:30am. -She would need to ask the MA who worked evening shift (3:00pm-11:00pm) on 11/18/19 if the endocrinologist was notified about Resident #2's FSBS result of High. -Her expectation was to document the endocrinology notifications in the progress notes.	{D 273}		

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{D 273}	Continued From page 4 Telephone interview with a Register Nurse (RN) at Resident #2's endocrinologist's office on 11/21/19 at 9:24am revealed: -When Resident #2's FSBS was outside of ordered parameters, the facility was expected to call the endocrinologist's office "right away." -Failure to address high blood sugars and administer insulin as ordered could have outcome to the resident including ketoacidosis (DKA), organ/system failure (liver and kidneys), and neuropathy. A second telephone interview with an RN at Resident #2's endocrinologist's office on 11/21/19 at 2:34pm revealed the office was notified of Resident #2's 7:30am FSBS result of 524 on 11/19/19 at 9:21am by a MA.(One hour and 51 minutes after the FSBS result was obtained). Interview with the Director of Resident Care (DRC) on 11/21/19 at 8:19am revealed: -When Resident #2's FSBS result was outside of ordered parameters, the physician was supposed to be notified at the time the FSBS was taken and outside of the parameters. -She expected physician notification within "a few minutes" after a FSBS was outside of the ordered parameters. Interview with the Executive Director (ED) on 11/21/19 at 3:19pm revealed if a resident's FSBS was outside ordered parameters, she expected the facility staff to call the provider "immediately." Attempted telephone interview on 11/21/19 at 2:53pm with MA who worked day shift on 11/19/19 was unsuccessful. Attempted telephone interview with Resident #2's primary care provider (PCP) on 11/21/19 at	{D 273}		

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{D 273}	Continued From page 5 3:03pm was unsuccessful. Refer to the interview with a Medication Aide /Supervisor (MA/S) on 11/21/19 at 9:25am. Refer to the interview with a medication aide (MA) on 11/21/19 at 10:43am. Refer to the interview with the Director of Resident Care (DRC) on 11/20/19 at 11:38am. 2. Review of Resident #1's current FL-2 dated 01/17/19 revealed diagnoses included type 2 diabetes mellitus, acquired hypothyroidism and essential hypertension. Review of a physician's order for Resident #1 dated 10/28/19 revealed: -There was a medication order for Humalog insulin, inject 5 units subcutaneously (SQ) with meals. -There was a second order for Humalog sliding scale insulin (SSI) to be administered SQ three times per day before meals per the following scale: for finger stick blood sugar (FSBS) result of 250-300, give 2 units; FSBS result of 301-350, give 4 units; for FSBS result of 351-400, give 6 units; for FSBS result of 401-450, give 8 units; for FSBS result of 451-500, give 10 units; if blood sugar is greater than 500, call MD (medical provider). Review of Resident #1's November 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Humalog 5 units SQ with meals scheduled to be administered at 7:00am, 12:00pm and 5:00pm. -There was an entry for FSBS and with SSI SQ three times daily per the following scale: FSBS	{D 273}		

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{D 273}	Continued From page 6 result of 250-300, give 2 units; FSBS result of 301-350, give 4 units; for FSBS result of 351-400, give 6 units; for FSBS result of 401-450, give 8 units; for FSBS result of 451-500, give 10 units; if blood sugar is greater than 500, call MD. Observation of the 12:00pm medication pass on the 300 hall on 11/19/19 revealed: -Resident #1's FSBS was 527 at 12:07pm. -The medication aide (MA) asked the resident "What did you eat" and the Resident #2 told the MA she had drank a lot of orange juice that morning (11/19/19). -The MA was not observed to ask Resident #2 how she was feeling or if she was experiencing any symptoms related to high blood sugar. -The MA administered the 5 units of scheduled Humalog at 12:12pm; no SSI was administered, as ordered. Interview with the MA on 11/19/19 at 12:08pm revealed she would have to contact Resident #1's primary care provider (PCP) to see how many units of Humalog SSI to administer to the resident. Observations on 11/19/19 from 12:10-1:05pm revealed: -At 12:10pm, Resident #1 walked to the dining room and sat down at the table. -The MA was out on the hall still administering medications to other residents. -Resident #1 was served her lunch at 12:44pm and began eating. -She was still in the dining room at 1:05pm. Interview with Resident #1 on 11/19/19 at 12:39pm revealed: -Her blood sugar would get "real high." -She would get nauseated when her blood sugar	{D 273}		

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{D 273}	Continued From page 7 was high. -She felt "a little nauseated now." -When her blood sugar was more than 500, her PCP was supposed to be called. -She did not know if the MA had time yet to call her PCP today (11/19/19). Observation of the MA on 11/19/19 at 12:51 pm revealed she was on the telephone at the front desk A second interview with the MA on 11/19/19 at 12:54pm revealed: -She had just called Resident #1's PCP about the FSBS of 527 (obtained on 11/19/19 at 12:07pm). -The PCP had given a verbal order for Resident #1 to receive 10 units of Humalog insulin. Observation on 11/191/19 at 1:21pm revealed: -The MA administered 10 units of Humalog to Resident #1 per the verbal order. -The MA did not ask Resident #1 how she was feeling. A second interview with Resident #1 on 11/19/19 at 4:40pm revealed: -She felt better now and was not nauseated. -Her blood sugar had not been re-checked but it should be checked before she ate supper. -"Sometimes" the MAs would ask her how she was doing when her sugar was high. -One [named] MA "always" asked how she was feeling but some of the MAs did not. -She could not recall the names of the MAs who did not ask her how she was feeling when her sugar was high. -When her sugar was low, the MAs usually asked how she was feeling and gave her orange juice, peanut butter crackers, or a snack. -She could not recall if the [named] MA who	{D 273}		

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{D 273}	Continued From page 8 checked her FSBS earlier that day (11/19/19) would normally ask her how she was if her sugar was low or high. Interview with a Medication Aide /Supervisor (MA/S) on 11/21/19 at 9:25am: -Resident #1 was non-compliant with her diet and had high blood sugars. -The MAs were expected to ask residents about symptoms of high or low blood sugar so they could be reported to the PCP. -If a resident was experiencing symptoms, the MAs were also expected to notify the Director of Resident Care (DRC) and/or supervisor or to go get the supervisor to help address the symptoms. -The MA should have stopped the medication pass and notified Resident #1's PCP of the FSBS result of 527 instead of waiting 43 minutes to notify the PCP. Interview with a second MA on 11/21/19 at 10:43am revealed: -When a resident's FSBS was outside of ordered parameters, she would call the PCP "right away". -She would check the resident for fatigue, slurred speech, and other physical changes. A second interview with the second MA on 11/21/19 at 11:07 am revealed: -If a resident's FSBS was above ordered parameters, she would call the PCP "immediately." -She would ask the resident how they were feeling. -If the resident was in the special care unit (SCU), she would watch how the resident was acting. Interview with the DRC on 11/21/19 at 8:19am revealed: -She would have expected the MA to have asked	{D 273}		

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{D 273}	Continued From page 9 Resident #1 if she was having symptoms when her FSBS result was 527 and reported the symptoms to the PCP. -She would expect the PCP to have been notified within "a few minutes" of the FSBS result of 527. Interview with Resident #1's PCP at 3:05pm on 11/21/19 revealed: -She would expect the MA to call her as soon as possible if a resident's FSBS was outside of the ordered parameters. -She thought the MA would automatically administer the highest dosage on the sliding scale if a resident's blood sugar was above the ordered SSI coverage. Interview with the Executive Director (ED) on 11/21/19 at 2:30pm revealed: -If a resident's FSBS was outside of ordered parameters, the MA should notify the physician by phone immediately, meaning "right then." -The MA should ask the resident if they were nauseous or if they felt bad in anyway as soon as possible. -If the MA was doing a medication pass, the MA should stop the medication pass, notify the PCP, and take care of the resident. A second interview with the ED on 11/21/19 at 3:19pm revealed: -If a resident's FSBS was above the ordered parameters, her expectations were to call the PCP "immediately," ask the resident how he/she was feeling, and complete supplemental documentation in the resident's progress notes. -The resident's name should be included on the "watch board" and in the 24-hour communication log shared between shifts. -Also, the supervisor should report the situation to the DRC.	{D 273}		

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{D 273}	Continued From page 10 Refer to the interview with a Medication Aide /Supervisor (MA/S) on 11/21/19 at 9:25am. Refer to the interview with a medication aide (MA) on 11/21/19 at 10:43am. Refer to the interview with the Director of Resident Care (DRC) on 11/20/19 at 11:38am. Interview with a Medication Aide /Supervisor (MA/S) on 11/21/19 at 9:25am revealed: -If a resident's FSBS result was outside of ordered parameters or if the FSBS result was "low", she would stop the medication pass and call the provider; she would expect the MAs to follow the same procedure. -The MAs were also expected to stop the medication pass and notify the provider, and Director of Resident Care (DRC) or the supervisor. Interview with a MA on 11/21/19 at 10:43am revealed: -When a resident's FSBS was outside of ordered parameters, she would call the PCP "right away". -She would not administer the sliding scale insulin to the resident until she talked to the PCP. -She would complete a resident's progress note to include what time she had called the PCP, the details of the conversation, and would follow through with any additional orders, for example, rechecking the resident's FSBS. Interview with the DRC on 11/20/19 at 11:38am revealed: -If a resident's FSBS result was outside of ordered parameters, the physician notification would be documented in the resident's progress notes.	{D 273}		

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{D 273}	Continued From page 11 -The expectation was for the MA to notify the physician "right then." -The MAs should notify the physician "immediately." _____ The facility failed to assure Resident #2's endocrinologist was notified when the resident's blood sugar was outside of ordered parameters of greater than 450 on 7 occasions between September 1, 2019 and November 18, 2019 for elevated blood sugars ranging from 467 - "high" and failed to assure immediate notification of the endocrinologist for Resident #2 blood sugar result of 524 on 11/19/19, resulting in a one hour 51 minute delay in notification. The facility failed to immediately notify Resident #1's primary care provider (PCP) of a blood sugar result of 527 outside of the ordered parameters, failed to ask the resident if she was experiencing symptoms of high blood sugar in accordance with the facility's established protocol, and failed to notify the PCP the resident was nauseated, resulting in a 43 minute delay in PCP notification of the FSBS result of 527 and no notification the resident was symptomatic. The facility's failure placed the resident's at increased risk for elevated blood sugars and symptoms of elevated blood sugars to include ketoacidosis and kidney damage which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on November 21, 2019 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 5, 2020.	{D 273}		

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{D 358}	Continued From page 12	{D 358}		
{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: FOLLOW-UP TO TYPE A1 VIOLATION. The Type A1 Violation was abated. Non-compliance continues. This is a Type B Violation Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner and in accordance with the facilities established procedures for 3 of 5 residents observed during the medication passes (#1, #6, and #7) including errors with rapid acting insulin being administered too soon before a meal (#1 and #6), an insulin pen not being prepared per manufacturer's guidelines before administration (#6) and failure to dilute a powdered laxative as ordered (#7); and for 2 of 5 sampled residents for record review (#1 and #2) including delays with implementation of orders to increase the dose of a long acting insulin (#1) and a delay in implementation of orders to increase the dose of a rapid acting insulin (#2).	{D 358}		

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LELAND HOUSE	1935 LINCOLN ROAD LELAND, NC 28451

(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 358}	Continued From page 13 The findings are: 1. The medication error rate was 12% as evidenced by 4 errors of 32 opportunities observed during the 12:00pm medication pass on 11/19/19 and the 8:00am medication pass on 11/20/19. a. Review of Resident #6's current FL-2 dated 10/24/19 revealed diagnoses included type 2 diabetes mellitus, hypothyroidism, hypertension and coronary artery disease. Review of a physician's order for Resident #6 dated 10/24/19 revealed: -There was an order for fingerstick blood sugar (FSBS) and Novolog Flexpen sliding scale insulin (SSI) to be administered daily at 12:00pm and before supper. (Novolog is a rapid acting insulin that begins to lower blood sugar within approximately 15 minutes of administration). -Administer insulin per the SSI as follows: for FSBS result of 0-200 give 0 units, 201-250 give 2 units 251-300 give 4 units, 301-350 give 6 units, 351-400 give 8 units, call MD (medical provider) if blood sugar is greater than 400. -Fingerstick blood sugars were scheduled daily at 7:00am, 12:00pm and 5:00pm. Observation on the 12:00pm medication pass on 11/19/19 from 11:57am-12:02pm revealed: -Resident #6's FSBS was 287 at 11:57am. -At 11:58am, the medication aide (MA) attached a new needle to the resident's Novolog Flexpen, dialed 2 units on the insulin pen, held it downward over the medication cart trash can, and depressed the button. -The MA then dialed 4 units on the insulin pen and administered the insulin to Resident #6 at 12:02pm.	{D 358}		

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{D 358}	Continued From page 14 Observation of the lunch meal service on 11/19/19 revealed Resident #6 was served her lunch meal and began eating lunch at 12:44pm. Telephone interview with a pharmacist at the facility's providing pharmacy on 11/19/19 at 4:34pm revealed: -Novolog Flexpen should be administered no more than 15 minutes before a meal or immediately afterward. -If the Novolog Flexpen was administered more than 15 minutes before a meal, the resident could experience hypoglycemia (low blood sugar). -The manufacturer of Novolog Flexpen recommended after a new needle was attached to the insulin pen, the pen should be held upright and tapped to move possible air bubbles to the top of the insulin cartridge. Two units were dialed on the insulin pen and with the insulin pen still held upright, the button was pressed. If insulin was seen at the tip of the needle, the insulin pen had been properly prepared to use. -If the insulin pen was not prepared correctly, the correct dosage of insulin administered could not be assured. Telephone interview with the facility's Licensed Health Professional Support Registered Nurses (LHPS RN) on 11/20/19 at 10:36am revealed: -She was responsible for completing the medication clinical skills competency validation for the facility's MAs. -When she validated the MAs competency, she observed to assure for use of the 2 unit air shot when administering insulin from insulin pens. -She tried to get the MAs to understand the difference between fast acting SSI and long acting insulin and not to administer fast insulin more than 15 minutes before a meal.	{D 358}		

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{D 358}	Continued From page 15 Interview with a MA on 11/21/19 at 11:05am revealed SSI should be administered 15-20 minutes before a resident ate because it was fast acting. Interview with the Director of Resident Care (DRC) on 11/21/19 at 8:19am revealed rapid acting insulin should be given within 15-20 minutes of a meal. Interview with the Director of New Builds and Requisitions and Clinical Support staff on 11/21/19 at 8:19am revealed rapid acting SSI should be administered within 15-20 minutes of a meal. Interview with Resident #6 on 11/21/19 at 10:22am revealed: -Her blood sugar was "up and down." -She took insulin when her sugar was "low." Interview with the Executive Director on 11/21/19 at 2:30pm revealed the MAs were expected to administer rapid acting insulin within 15 minutes of a meal, which was how they were trained by the corporate Registered Nurse (RN). Attempted telephone interview with Resident #6's primary care provider (PCP) on 11/19/19 at 4:10pm was unsuccessful. b. Review of Resident #1's current FL-2 dated 01/17/19 revealed diagnoses included type 2 diabetes mellitus, acquired hypothyroidism and essential hypertension. Review of a physician's order for Resident #1 dated 10/28/19 revealed Humalog U-100 insulin, 100 units per ml, inject 5 units with meals.	{D 358}		

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{D 358}	Continued From page 16 (Humalog is a rapid acting insulin that begins to lower blood sugar within approximately 15 minutes of administration). Review of Resident #1's electronic medication administration record (eMAR) for November 2019 revealed there was an electronic entry for Humalog U-100; 100/units inject 5 units with meals scheduled to be administered at 7:00am, 12:00pm and 5:00pm. Observation of the 12:00pm medication pass on 11/19/19 revealed Resident #1 received 5 units of Humalog U-100 at 12:12pm. Observation of the lunch meal service on 11/19/19 revealed Resident #1 was served her lunch meal and began eating lunch at 12:44pm. Telephone interview with a pharmacist at the facility's providing pharmacy on 11/19/19 at 4:34pm revealed: -Humalog should be administered no more than 15 minutes before a meal. -If Humalog was administered more than 15 minutes before a meal, the resident could experience hypoglycemia (low blood sugar). Interview with Resident #1 on 11/19/19 at 4:40pm revealed staff usually checked her blood sugar and administered her insulin about 45 minutes to one hour before she ate. Interview with a medication aide/supervisor (MA/S) on 11/21/19 at 8:19am revealed: -Medications ordered with meals were supposed to be administered with meals. -The time frame would be from when the resident started eating the meal through the time they finished eating their meal.	{D 358}		

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{D 358}	Continued From page 17 -The MAs were trained to administer insulin in a private room when the resident was ready to be served their meal or as soon as they finished their meal. Interview with the Director of Resident Care (DRC) on 11/21/19 at 8:19am revealed she expected medications ordered with meals to be given with the meal. Interview with the Director of New Builds and Requisitions and Clinical Support staff on 11/21/19 at 8:19am revealed medications ordered with meals should be administered with the first bite of a meal. Interview with the Executive Director (ED) on 11/21/19 at 2:30pm revealed medications ordered with meals were expected to be administered with meals or if the resident could not eat a meal, a snack was to be given. c. Review of Resident #7's current FL-2 dated 09/18/19 revealed diagnoses included chronic schizophrenia, obsessive compulsive disorder and diabetes mellitus Type II. Review of a physician's order for Resident #7 dated 10/28/19 revealed a medication order for Miralax 17 grams (gm) daily diluted in 8 ounces (oz) of liquid. (Miralax is a laxative). Review of Resident #7's electronic medication administration record (eMAR) dated November 2019 revealed there was an entry for Miralax 17gm diluted in 8oz of liquid to be administered every day at 8:00am. Observation of the 8:00am medication pass on 11/20/19 revealed:	{D 358}		

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	HAL010007	A. BUILDING: _____ B. WING _____	R-C 11/21/2019

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{D 358}	Continued From page 18 -The medication aide (MA) prepared Resident #7's oral medications for administration to include tablets and capsules. -The MA prepared Miralax for administration by emptying a single dose packet labeled Miralax 17gm into plastic cup (the bottom of the cup was marked 9oz) then poured an unmeasured amount of water into the cup. -At 8:29am, the MA was prompted regarding measuring the amount of water diluting the Miralax; however, Resident #7 drank the Miralax and swallowed his oral pills and capsules with the Miralax at 8:29am. Interview with the MA on 11/2019 at 8:33am revealed: -She did not know if there was 8oz of water that she poured into the cup with the Miralax. -She had been told by other MAs to add water to the last small ring on the cup. -She had never measured the water to assure Miralax was diluted in 8oz of water. Interview with the Executive Director (ED) on 11/21/19 at 2:30pm revealed: -When a medication was ordered with 8ozs of liquid, she expected it to be given with 8 ounces of liquid. -The MAs were expected to measure the 8ozs of liquid. 2. Review of Resident #1's current FL-2 dated 01/17/19 revealed diagnoses included history of transient ischemic attacks, type II diabetes mellitus, essential hypertension, and hypothyroidism. a. Review of a physician's order for Resident #1 dated 09/21/19 revealed an order to increase	{D 358}		

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{D 358}	Continued From page 19 Lantus insulin from 17 units (U) to 20 U subcutaneously (SQ) at bedtime. (Lantus insulin is a long acting insulin used to lower blood sugar). Review of Resident #1's September 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus 17U SQ scheduled at 8:00pm with a start date documented as 09/19/19 and an end date documented as 09/25/19 and documentation of administration of 17U from 09/21/19 - 09/24/19 at 8:00pm. -Resident #1's documented finger stick blood sugars (FSBS) ranged from 216 - 496 from 09/21/19 - 09/24/19. -There was an entry for Lantus 20U SQ scheduled at 8:00pm with a start date documented as 09/25/19; Lantus 20U was documented as first administered on 09/25/19. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/20/19 at 4:30pm revealed Resident #1's order to increase Lantus to 20U dated 09/21/19 was received at the pharmacy on 09/23/19. Interview with the Director of Resident Care (DRC) on 11/21/19 at 8:19am revealed: -The order to increase Resident #1's Lantus to 20U dated 09/21/19 and was received at the facility via fax on 09/22/19. -Resident #1 was administered 17U of Lantus from 09/21/19 - 09/24/19. -The order was sent to the pharmacy on 09/23/19. -She expected new orders to be faxed to the pharmacy upon receipt so the medication could be dispensed from the pharmacy. -The expectation for implementation of new	{D 358}		

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{D 358}	Continued From page 20 orders was when the medication was received from the pharmacy. Refer to the interview with the Director of Resident Care (DRC) on 11/20/19 at 11:38am. Refer to the second interview with the DRC on 11/21/19 at 8:19am. Refer to the interview with medication aide/supervisor (MA/S) on 11/21/19 at 9:25am. Refer to the interview with the Executive Director on 11/21/19 at 2:30pm. b. Review of a physician's verbal order for Resident #1 dated 10/10/19 revealed an order to increase Lantus to 22 units (U) subcutaneously (SQ) at bedtime. Review of Resident #1's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Lantus 20U SQ scheduled administration at 9:00pm with a start date documented as 09/25/19 and an end date documented as 10/17/19. -There was documentation Lantus 20U was administered at 9:00pm from 10/10/19-10/16/19. -Resident #1's documented FSBS results ranged from 322 - 577 from 10/10/19 - 10/16/19. -There was an entry for Lantus 22U SQ scheduled administered at 9:00pm with a start date documented as 10/17/19. -Lantus 22U was documented as being first administered on 10/17/19; there was no documentation that 22U was administered from 10/10/19 through 10/16/19. Telephone interview with a pharmacist from the	{D 358}		

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{D 358}	Continued From page 21 facility's contracted pharmacy on 11/20/19 at 4:30pm revealed the order to increase Resident #1's Lantus to 22U dated 10/10/19 was received at the pharmacy on 10/16/19. Interview with a medication aide (MA) on 11/21/19 at 10:43am revealed: -When a verbal order was received, it was faxed to the physician for a signature. -She called the ordering provider's office to confirm receipt of the order. -She documented in the progress notes what time the physician was called, what the physician stated and that the order was faxed to the pharmacy. -Verbal orders were to be implemented immediately. Interview with a second MA on 11/21/19 at 11:05am revealed the process for verbal orders was to document the verbal order and implement the verbal order "immediately." Interview with Resident #1 on 11/21/19 at 8:45am revealed her blood sugar had been "good" until 6 months ago and then it started being really high. Interview with medication side/supervisor (MA/S) on 11/21/19 at 9:25am: -The system for verbal orders was to write up the order and fax it to the primary care provider (PCP) and pharmacy so it could be put on the eMAR. -The PCP had to sign the new verbal order within 15 days. -A new verbal medication order would be faxed to the pharmacy and the pharmacy would profile the medication. -Profile meant the medication would show as due to be administered.	{D 358}		

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{D 358}	Continued From page 22 -"Usually", whoever received the verbal order would be responsible for faxing the order to the pharmacy. -Verbal orders were to be implemented at the time of receipt. -When questioned about the time frame of implementation of Resident #1's verbal order for Lantus dated 10/10/19, she did not respond with an answer. Interview with the Director of Resident Care (DRC) on 11/21/19 at 8:19am revealed: -When a verbal order was obtained, it was faxed to the physician to be signed and faxed to the pharmacy. -A verbal order should start immediately upon receipt of the order. -She could not say if there was a delay in implementing Resident #1's verbal order dated 10/10/19 that was not started until 10/17/19; she would need to ask another [named] staff. Interview with the Executive Director (ED) on 11/21/19 at 2:30pm revealed: -Her expectation was to implement verbal orders immediately. -She expected action on the verbal order and then for the MAs to document in the progress notes. -The MA should document in the progress notes that a verbal order was received, what the order was and fax the order to the provider to be signed as soon as possible (ASAP). Refer to the interview with the Director of Resident Care (DRC) on 11/20/19 at 11:38am. Refer to the second interview with the DRC on 11/21/19 at 8:19am.	{D 358}		

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{D 358}	Continued From page 23 Refer to the interview with medication aide/supervisor (MA/S) on 11/21/19 at 9:25am. Refer to the interview with the Executive Director on 11/21/19 at 2:30pm. 3. Review of Resident #2's current FL-2 dated 9/23/19 revealed diagnoses included diabetes mellitus type II, anxiety, essential hypertension, Vitamin B deficiency, osteoarthritis, and atherosclerotic heart disease. a. Review of a physician's order for Resident #2 dated 11/14/19 revealed: -Increase Lantus from 12 units (U) to 16U subcutaneously (SQ) at bedtime. (Lantus is a long acting insulin used to lower blood sugar). -There was a handwritten documentation the medication was approved for eMAR which read "11/19/19" and the two initials of the facility staff member. -There was a handwritten documentation the medication was in the building which read "11/19/19" and the two initials of the facility staff member. Review of Resident #2's Resident Progress Notes dated 11/14/19 at 2:00pm revealed: -The medication aide/supervisor (MA/S) documented she received a new order to increase Resident #2's Lantus to 16U SQ at bedtime. -There was documentation the order was faxed to the pharmacy. Review of Resident #2's November 2019 electronic Medication Administration Record (eMAR) -There was an entry for Lantus U-100 insulin pen,	{D 358}		

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{D 358}	Continued From page 24 inject 12U SQ at bedtime with a start date documented as 09/30/19 and an end date documented as 11/17/19. -There was documentation Resident #2 was administered 12U of Lantus on Thursday (11/14/19), Friday (11/15/19), Saturday (11/16/19), and Sunday (11/17/19) at 8:00pm. -There was an entry for Lantus U-100 insulin pen, inject 16U SQ at bedtime with a start date documented as 11/17/19. -Resident #2 documented FSBS results ranged from for 144-401 from 11/14/19-11/17/19. -There was documentation Resident #2 first received 16U of Lantus on 11/18/19 at 9:00pm. -Her FSBS result on 11/18/19 was 455 at 7:30am and "High" at 5:00pm. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/20/19 at 12:35pm revealed: -On 11/14/19, the pharmacy received Resident #2's medication order dated 11/14/19 to increase Lantus to 16U at bedtime. -On 11/15/19, Lantus insulin was dispensed from the pharmacy to the facility for Resident #2. -On 11/15/19, Lantus was imported to Resident #2's eMAR by the pharmacy. -On 11/16/19 at 8:36am, the facility received the Lantus. Interview with the Director of Resident Care (DRC) on 11/20/19 at 11:38am revealed: -The physician order dated 11/14/19 was "sent over late" from the resident's endocrinology office to the facility on 11/14/19. -The new order was not imported by the pharmacy due to "system issues" all last week. -If a new medication order was not present on the eMAR, the medication aides (MAs) would know on "paper"; they had the order and would have	{D 358}		

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{D 358}	Continued From page 25 documented the administration in the resident's progress notes. Second interview with the DRC on 11/20/19 at 4:35pm revealed: -There was a medication error related to Resident #2's physician order dated 11/14/19 due to the delay in starting Lantus 16U SQ at bedtime. -The first dose of Lantus 16U SQ at bedtime was administered on 11/18/19. -"They" discovered the medication error related to Lantus yesterday afternoon (11/19/19) and she had completed the internal paperwork outlining the medication error. Interview with MA on 11/21/19 at 11:07am revealed: -The increased dose of Lantus for Resident #2 was not reported to her during shift report on 11/15/19. -She did not know why the increased dose of Lantus was not administered on 11/16/19 and 11/17/19. Telephone interview with the Registered Nurse (RN) at Resident #2's endocrinologist's office on 11/21/19 at 9:24am revealed: -The endocrinologist was not aware there was a delay in starting the increased doses of Lantus ordered on 11/14/19. -Failure to administer the insulin as ordered could result in outcomes to the resident including ketoacidosis (DKA), organ/system failure (liver and kidneys), and neuropathy. -The expectation would be to implement any order as soon as possible (ASAP), at the time of receipt. Refer to the interview with the Director of Resident Care (DRC) on 11/20/19 at 11:38am.	{D 358}		

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(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 358}	Continued From page 26 Refer to the second interview with the DRC on 11/21/19 at 8:19am. Refer to the interview with medication aide/supervisor (MA/S) on 11/21/19 at 9:25am. Refer to the interview with the Executive Director on 11/21/19 at 2:30pm. b. Review of a physician's order for Resident #2 dated 11/14/19 revealed: -There was a medication order to increase Novolog flex pen from 6 units (U) to 8U subcutaneously (SQ) at dinner and continue with 6U of Novolog flex pen at breakfast and lunch. -There was a handwritten documentation the medication was approved for eMAR which read "11/19/19" and the two initials of the facility staff member. -There was a handwritten documentation the medication was in the building which read "11/19/19" and the two initials of the facility staff member. Review of Resident #2's Progress Notes revealed: -On 11/14/19 at 2:00pm, the medication aide/supervisor (MA/S) MA/S documented receipt of an order to increase Novolog flex pen to 8U SQ at dinner and to continue with 6U of Novolog flex pen at breakfast and lunch with documentation the order was faxed to the pharmacy. -On 11/14/19 at 8:08pm, the MA/S documented resident received new orders to increase Novolog to 8U at dinner time, resident also received the 8U prior to dinner which was recorded as late entry on 11/19/19 at 1:10pm. -On 11/14/19 at 8:09pm, the MA/S documented	{D 358}		

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	HAL010007	A. BUILDING: _____ B. WING _____	R-C 11/21/2019

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{D 358}	Continued From page 27 resident received 8U prior to eating supper as per the PCP which was recorded as late entry on 11/19/19 at 1:10pm. -On 11/19/19 at 1:21pm the MA/S documented per new order the resident received 8U of Novolog at dinner time on Saturday (11/16/19), and Sunday (11/17/19) which was recorded as late entry on 11/19/19 at 1:23pm. Review of Resident #2's November 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog Flex insulin pen, inject 6U three times daily before meals to be administered at 7:00am, 12:00pm, and 5:00pm plus sliding scale insulin with a start date of documented as 10/01/19 and an end date documented as 11/19/19. -There was documentation on Thursday (11/14/19), Friday (11/15/19), Saturday (11/16/19), Sunday (11/17/19), and Monday (11/18/19) that Resident #2 was administered 6U of Novolog flex pen at 7:00am, 12:00pm, and 5:00pm. -Resident #2's FSBS result range from 11/14/18-11/18/19 was 144-"High." -There was an entry for Novolog Flex insulin pen, inject 8U SQ with supper call MD if < (less then) 70 or > (greater than) 450 with a start date documented as 11/19/19. -Novolog flex pen was first documented as administered at the 8U dose with supper on 11/19/19 at 5:00pm. -On 11/19/19, her FSBS result was 524 at 7:30am, 471 at 12:00pm, and 361 at 5:00pm. Interview with the Director of Resident Care (DRC) on 11/20/19 at 11:38am revealed: -The physician order dated 11/14/19 was "sent over late" from the endocrinologist's office to the	{D 358}		

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{D 358}	Continued From page 28 facility on 11/14/19. -The new order was not imported by the pharmacy due to "system issues" all last week. -The new order for the increase in the Novolog Flex pen to 8U at dinner time did not appear on the eMAR because the pharmacy was requesting clarification orders related to the resident's Novolog sliding scale insulin. (SSI). -Novolog insulin was administered at the increased dose of 8U on 11/15/19, 11/16/19, and 11/17/19 to Resident #2. -If a new medication order was not present on the eMAR, the medication aides (MAs) would know on "paper"; they had the order and would have documented the administration in the resident's progress notes. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/20/19 at 12:35pm revealed: -On 11/14/19, the pharmacy received the physician order for Resident #2 dated 11/14/19 to increase Novolog flex pen to 8U at dinner and to continue Novolog flex pen at 6U at breakfast and at lunch. -Fax clarification was sent to the facility related to the 11/14/19 physician order for the Novolog increase to 8U at dinner, to confirm if the Novolog SSI would be affected on 11/14/19. -The pharmacy received a fax response from the facility on the clarification on 11/15/19 with no changes noted to Resident #2's Novolog SSI. Second interview with the DRC on 11/20/19 at 4:35pm revealed: -There was a medication error related to the physician order dated 11/14/19 due to the delay in starting the 8U of Novolog at dinner. -"They" discovered the medication error related to Novolog flex pen yesterday afternoon (11/19/19)	{D 358}		

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{D 358}	Continued From page 29 and she had completed the internal paperwork outlining the medication error. Interview with MA on 11/21/19 at 11:07am revealed: -She administered 8U of Novolog SQ Resident #2 at 5:15pm on 11/16/19 and 11/17/19. -She documented the administration of 8U of Novolog SQ at dinner on 11/16/19 and 11/17/19 in the resident's progress notes as a late entry on 11/19/19 at 1:23pm. -She was aware of the physician order dated 11/14/19 outlining the increased Novolog at dinner because she saw the physician order and she received information about the new order for Novolog during shift report on 11/15/19. Telephone interview with the Registered Nurse (RN) at Resident #2's endocrinologist's office on 11/21/19 at 9:24am revealed: -The endocrinologist was not aware there was a delay in starting the increased dose of Novolog flex pen at dinner ordered on 11/14/19. -Failure to administer the insulin as ordered could result in outcomes to the resident including ketoacidosis (DKA), organ/system failure (liver and kidneys), and neuropathy. -The expectation would be to implement any order as soon as possible (ASAP), at the time of receipt. Refer to the interview with the Director of Resident Care (DRC) on 11/20/19 at 11:38am. Refer to the second interview with the DRC on 11/21/19 at 8:19am. Refer to the interview with medication aide/supervisor (MA/S) on 11/21/19 at 9:25am.	{D 358}		

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{D 358}	Continued From page 30 Refer to the interview with the Executive Director on 11/21/19 at 2:30pm. c. Review of a physician's order for Resident #2 dated 10/28/19 revealed: -There was an order for fingerstick blood sugar (FSBS) and Novolog Flexpen sliding scale insulin (SSI) to be administered per sliding scale three times daily with meals at 7:30am, 12:00pm, and 5:00pm. -Novolog SSI was to be administered per the following scale: if blood sugar was less than 70, call MD; if FSBS was 150 to 200, give 2 Units (U); for FSBS 201 to 250, give 4U; if FSBS was 251 to 300, give 6U; if FSBS was 301 to 350, give 8U; if FSBS was 351 to 400, give 10U; if FSBS was 401 to 450, give 12U; and if blood sugar was greater than 450, call endocrinology. Review of the Resident #2's November 2019 electronic medication administration record (eMAR) -There was an entry FSBS and Novolog Flexpen SSI to be administered per the following sliding scale three times daily with meals at 7:30am, 12:00pm, and 5:00pm: if FSBS was less than 70, call MD; if FSBS was 150 to 200, give 2 Units; if FSBS was 201 to 250, give 4 Units; if FSBS was 251 to 300, give 6 Units; if FSBS was 301 to 350, give 8 Units; if FSBS was 351 to 400, give 10 Units; if FSBS was 401 to 450, give 12 Units; and if FSBS was greater than 450, call endocrinology. -On 11/18/19 at 7:30am, Resident #2's FSBS result was documented as 455; there was documentation 0 units of Novolog SSI was administered on 11/18/19 at 7:30am. -On 11/18/19 at 5:00pm, Resident #2's FSBS result was documented as "High"; the documentation was blank for the number of Novolog SSI administered at 5:00pm.	{D 358}		

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{D 358}	Continued From page 31 Review of the Resident #2's eMAR Administration Compliance Report dated 11/01/19-11/19/19: -There was documentation dated 11/18/19 at 7:30am Novolog SSI was not administered due to condition. -There was documentation dated 11/18/19 at 5:00pm Novolog SSI was not administered; "called MD" (medical provider). Interview with medication aide (MA) on 11/21/19 at 3:06pm revealed: -On 11/18/19 at 7:30am, she "forgot" to notify Resident #2's endocrinologist or PCP of her FSBS result of 455. -She did not administer SSI to the Resident #2 at 7:30am. Interview with the DRC on 11/21/19 at 3:25pm revealed Resident #2's eMAR outlined her 5:00pm FSBS result was "High" and acknowledged the eMAR did not show any SSI was administered on 11/18/19 at 5:00pm. Refer to the interview with the Director of Resident Care (DRC) on 11/20/19 at 11:38am. Refer to the second interview with the DRC on 11/21/19 at 8:19am. Refer to the interview with medication aide/supervisor (MA/S) on 11/21/19 at 9:25am. Refer to the interview with the Executive Director on 11/21/19 at 2:30pm. Interview with the Director of Resident Care (DRC) on 11/20/19 at 11:38am revealed: -When a new physician order was received, the staff who obtained the order was responsible for	{D 358}		

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{D 358}	Continued From page 32 faxing the order to the pharmacy. -Once the facility received the medication from the pharmacy, the medication order was verified by the Care Managers and would appear on the electronic eMAR for administration. Second interview with the DRC on 11/21/19 at 8:19am revealed: -When a new order was received, it was to be faxed to the pharmacy. -The time frame for implementing new orders was when the medication was received from the pharmacy. Interview with medication aide/supervisor (MA/S) on 11/21/19 at 9:25am revealed: -New medication orders were faxed to the pharmacy. -The pharmacy would profile the medication. -Profile meant the medication would show up in a format as due to be administered. Interview with the Executive Director (ED) on 11/21/19 at 2:30pm revealed: -New orders were to be implemented immediately using the Bucket System. -Once a medication order was faxed to the pharmacy the order, would be placed in the bucket system. -After orders were faxed to the pharmacy, they were placed in a folder. -Once the order was entered in the electronic medication system by the pharmacy, the order was placed in another folder to wait for medication delivery. -Orders that were incomplete, required a physician clarification, needed a hard copy, or required prior authorization by the physician were placed in a separate folder. -New orders were communicated using the	{D 358}		

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{D 358}	Continued From page 33 bucket system and the 24 hour report written by the MAs. The 24 hour report was kept on the medication cart. _____ The facility failed to assure medications were administered as ordered. Observations of the medications passes revealed 2 of 2 residents observed who were administered rapid action insulins received the insulins outside of the manufacturer's recommended administration guidelines and the facilities established procedures resulting in Residents #6 being administered rapid acting insulin 42 minutes before her meal, placing her at risk for symptoms of low blood sugar to include fainting, fatigue, lightheadedness, shakiness, nausea or vomiting, mental confusion, or unresponsiveness and Resident #1 not receiving her rapid acting insulin with her meal, as ordered. There was a three day delay in implementation of an increase in the dose of Resident #1's Lantus (a long insulin) from 09/21/19 - 09/24/19. Resident #1's finger stick blood sugar (FSBS) results ranged from 216 - 496 during the 3 days in which the Lantus dose was not administered at the increased dose, as ordered. There was six day delay in implementation of a medication order to increase Resident #1's Lantus dose from 10/10/19 - 10/16/19 during which time the resident's FSBS ranged from 322 - 577. There was a four day delay in implementation of an order to increase Resident #2's Lantus (a long acting insulin) from 11/14/19-11/18/19. Resident #2's FSBS results ranged from 144 -"High" from 11/14/19 - 11/18/19 which placed the resident at risk for diabetic ketoacidosis and kidney damage. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.	{D 358}		

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{D 358}	Continued From page 34 The facility provided a plan of protection in accordance with G.S. 131D-34 on November 21, 2019 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 5, 2020.	{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 were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care and medication administration. 1.The facility failed to assure the acute and chronic health care needs were met for 2 of 5 sampled residents (#1 and #2) related to primary care provider (PCP) notification of elevated fingerstick blood sugar results (#1 and #2). 2. Based on observations, interviews, and record reviews, the facility failed to assure medications	{D912}		

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{D912}	Continued From page 35 were administered as ordered by a licensed prescribing practitioner for 3 of 5 residents (#1, #6, and #7) observed during the medication pass related to insulin being administered too soon before a meal (#1 and #6) and a Novolog Flexpen not prepared correctly before administration (#6) and the mixing of a laxative (Miralax) (#7); and 2 of 5 sampled residents (#1 and #2) for record review related to a delay increasing Lantus insulin as prescribed by the practitioner for resident (#1) and a delay increasing Novolog Flexpen and Lantus Insulin as prescribed by the practitioner for resident (#2).	{D912}		