STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060149	A. BUILDING: _____ B. WING _____	R 06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

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{D 000}	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a follow-up survey and complaint investigation via desk review on June 2, 2020 through June 18, 2020, onsite June 16, 2020 with an exit conference via telephone on June 18, 2020. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on June 5, 2020.	{D 000}		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to respond immediately and in accordance with the facility's established policy and procedures for 1 of 5 sampled residents (Resident #2) who was unresponsive due to a hypoglycemic episode which required immediate emergency services. Review of Resident #2's current FL2 dated 09/06/19 revealed diagnoses included hyperlipidemia, hypertension, atrial fibrillation,	D 271		

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coronary artery disease, diabetes, and vitamin D deficiency.

Review of the physician's hypoglycemia standing order dated 12/18/19 revealed if the resident was unconscious immediately call 911.

Review of the Emergency Medical Service (EMS) report for Resident #2 dated 06/09/20 revealed:
-The facility called EMS at 9:04am.
-The EMS unit was dispatched to the facility at 9:04am for hypoglycemia and arrived at the facility at 9:29am.
-The paramedics found the resident lying on the couch in the common area.
-The resident had a Glasgow Coma Scale evaluation (GCS is a tool that healthcare providers use to measure a person's level of consciousness).
-Resident #2's GCS was 8 out of a maximum of 15, and diaphoretic (sweaty and cool to the touch.
-Staff reported "we just got on at 7:00am, so we don't know what's going on".
-The staff presented the following blood sugar readings to EMS as follows; BS 77mg/dl at 7:40am, 64 mg/dl at 8:00am, 113 mg/dl at 8:45am and 87 mg/dl at 8:58am.
-The staff did not report a reason why they waited so long to call EMS, but stated that the resident's condition (GCS 8) was the same when they initially saw him this morning.
-The resident had OJ around his mouth and on his shirt where the staff attempted to give prior to EMS arrival.
-IV access was obtained and the resident was given 150mg/dl of D10 (10% Dextrose) and his mental status improved.
-Vital signs taken at 9:29am (on arrival) were as follows; GCS 8, heart rate 70, respiratory rate 14, blood pressure 160/70, oxygen status 95% on

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room air, and a blood sugar of 22.
-Vital signs at 9:30am (after D10), were as follows GCS 15, heart rate 70, blood pressure 136/65, oxygen status 95% on room air and a blood sugar of 90.
-The resident was transported to the hospital and arrived at 10:13am with a GCS of 15, alert and oriented.

Review of the 2017 American Heart Association Basic Life Support guide for healthcare providers revealed:
-The first link in the treatment of any emergency was to recognize that an emergency exists and phone the appropriate emergency response number.
-Early access to the emergency response system in the healthcare community was to ensure that additional rescuers and those capable of providing advanced life support arrive as quickly as possible.
-If a victim was unresponsive, shout for help, activate the emergency response system, observe breathing.
-If no breathing or only gasping, or pulse, begin cardio-pulmonary resuscitation (CPR).

Review of a nurses note dated 06/09/20 at 11:03am.
-The entry was documented as a late entry completed by a medication aide (MA).
-Resident #2 was observed sitting in the dayroom unresponsive at 7:40am.
-The blood sugar was taken and it was 77.
-Resident #2 was given OJ with sugar to help bring his blood sugar back up.
-At 8:00am Resident #2's blood sugar was rechecked, and it was 64.
-At 8:45am a blood sugar was checked, and it was 113.

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-The primary care physician (PCP) was called to be advised on the next procedure.
-The PCP advised to continue giving sweet OJ until resident blood sugar reached 180.
-At 8:58am recheck Resident #2's blood sugar and it was 87.
-The PCP was called again, and the PCP advised to send Resident #2 to the emergency room.
-At 9:11am the EMS arrived and checked Resident #2's blood sugar and it was 22.
-Resident #2 was given an IV and transported to the hospital for further evaluation.

Review of the Emergency Department provider notes dated 06/09/20 at 10:20am revealed:
-The chief complaint was documented as decreased blood sugar (symptomatic).
-The history and physical was documented as a 70-year-old male brought in by EMS after being found unresponsive in his nursing facility this morning. The patient was initially alert this morning and received a dose of his insulin. He gets, Levemir, Januvia, Novolog and Glimepiride. He had not eaten since yesterday morning. He became unresponsive. It was documented that the patient had his glucose checked 4 times between 7:30am and 9:00am, and all of the values were between 70 - 115. However, when EMS arrived at 9:15am the patient's blood sugar was 22. The patient is now awake, alert, oriented and appropriate after receiving dextrose from EMS.
-A blood sugar was documented as 69.
-A Complete Metabolic Panel was drawn and the result of the blood glucose was documented as 120.
-Final diagnoses were documented as hypoglycemia due to insulin and transient alteration of awareness.
-Resident #2 was discharged back to the facility

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at 2:00pm.

Review of the Incident Report dated 06/09/20 revealed:
-The report was created at 10:55am by a MA.
-Resident #2 was found by a staff member in the day room, alone, unresponsive, and sweating.
-The resident was documented as having a cognitive impairment/dementia.
-There were no injuries documented.
-First-aid was documented as not administered.
-Resident #2's level of consciousness was documented as unresponsive.
-Resident 2 was transported to the emergency room by EMS.
-Resident #2 returned from the hospital on 06/09/20 with a diagnosis of Hypoglycemia and to follow up with PCP.

Telephone interview with a medication aide (MA) on 06/17/20 at 9:36am revealed:
-She worked 7:00am to 7:00pm shift the last 5 years.
-She found Resident #2 unresponsive in the day room on 06/09/20 at 7:40am.
-Resident #2 was sweating, she performed a "sternal rub" and Resident #2 "moaned" (a sternum rub is a painful stimulus applied to the sternum who is not responding verbally in efforts to determine extent of unconsciousness).
-She checked Resident #2's blood sugar and it was 77.
-She gave Resident #2 "sugared orange juice" because Resident #2's blood sugar was usually high, and she was afraid his blood sugar would drop more.
-She held Resident #2's head in her arm and poured a little bit of sugared OJ in his mouth every minute or so.
-Around 8:00am she rechecked his blood sugar

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and it was 64. She continued with the orange juice and sugar.
-Around 8:45am she rechecked Resident #2's blood sugar and it was 113 and she called the primary physician at that point because she felt his blood sugar would continue to drop. Resident #2 was still unresponsive at this point.
-She considered a blood sugar of 113 for Resident #2 was low since his blood sugars were normally in the 200-300 range.
-The physician instructed her to continue with the sugared OJ until the blood sugar was above 180.
-She did not inform the physician the resident remained unresponsive because Resident #2 responded to the sternal rub with moaning.
-About 9:00am she rechecked Resident #2's blood sugar and it was 87 and she called the physician again, informed him of the blood sugar and Resident #2 was unresponsive.
-The physician instructed her to call 911.
-The EMS arrived after 9:00am.
-Resident #2 was given an IV by the paramedics and "sugar water" in her IV and loaded Resident #2 on the stretcher and he began to wake up.
-She did not know if Resident #2 received all of the OJ because it was spilling out onto his chin and shirt so she gave more.

Telephone interview with the PCP on 06/12/20 at 3:03pm revealed:
-On 06/09/20, he received a call from a MA after 8:00am concerning Resident #2 was found unresponsive and his blood sugar was in the 70's-80's and OJ with sugar had been administered, Resident #2 normalized with a blood sugar of 113-120.
-He told the MA to make sure the resident ate and continue to monitor.
-He received a second call informing that the resident was unresponsive, blood sugar of 70,

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and he gave the order to send the resident to the hospital.
-He had a standing order for hypoglycemia and if the resident was unconscious, staff was to immediately call 911.
-Resident #2's blood sugar was normally in the 200-300's and this was very unusual for him to be this low and considered this very serious for Resident #2.
-If Resident #2's blood sugar was lower than 150 it could have been caused if Resident #2 received a higher dosage of his insulin, (more than was ordered) or not getting the proper food intake.
-It was important to maintain his normal blood sugar (200-300's) before and after meals.
-A drop in Resident #2's blood sugar less than 70 after receiving too much insulin could result in sweating, confusion, inability to concentrate, for example could cause the inability to call for help.
-A drop in Resident #2's blood sugar less than 70 could cause an irregular heart rhythm and with Resident #2's cardiac history, including coronary artery disease, and atrial fibrillation along with a blood sugar less than 70 and loss of consciousness could lead to death if not treated early enough.
-He expected the staff to call 911 as soon as the resident was found unresponsive.
-A blood sugar less than 50 was considered life threatening, "more so for" Resident #2 because Resident #2 could become unresponsive and go into insulin shock (too much insulin in the blood causing low blood sugar), and or cardiac arrest, which could lead to death.

Telephone interview with Resident #2 on 06/17/20 at 2:45pm revealed:
-On 06/09/20, his blood sugar dropped low and he did not remember anything after sitting in the dayroom once he received his morning insulin

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and medications until he woke up being loaded into the ambulance.
-He asked the EMS person what had happened.
-He was told that his blood sugar was low, and they gave him something in his IV to make it better.
-He did not remember anyone giving him OJ just being loaded into the ambulance.
-He had not eaten since breakfast the day before (06/08/20).
-He informed the MAs over the weekend he was not eating because he did not feel well and too hot, as well as the MA on 06/08/20.
-He had not been feeling good since the weekend. He felt hot, sweaty and tired.
-The AC was out at the facility, so he was really hot the last several days.
-He went to the hospital and was given fluids and "sugar water" in his IV and was sent back to the facility that afternoon.

Interview with the Administrator on 06/16/20 at 12:22pm and 06/17/20 at 2:16pm revealed:
-She was aware Resident #2 was sent to the hospital on 06/09/20 because she had just arrived at the facility as the medics were loading Resident #2 into the ambulance.
-The MA gave her a verbal report that Resident #2's blood sugar was low, OJ with sugar was administered, and the PCP wanted Resident #2 to go to the hospital for evaluation.
-She did not know Resident #2 was unresponsive until she read the nurses note dated 06/09/20 on 06/16/20.
-There was a facility policy and hypoglycemia standing order if a resident was unresponsive to call 911 first and the PCP after.
-She expected the staff to call 911 when any resident was found unresponsive, immediately.

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D 271	Continued From page 8 The facility failed to respond in accordance with the facility's policy and procedures for assuring 911 was contacted immediately for Resident #2 who became unresponsive. The facility's failure to respond immediately prevented first responders from arriving as quickly to provide advanced life support resulting in an 84 minute delay to receive emergency medication for an unconscious resident, to treat a blood sugar of 22. This failure resulted in serious risk for physical harm which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 06/18/20. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 18, 2020.	D 271		
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to provide care and services which are adequate, appropriate, and in compliance with Federal and State laws and rules and regulations for 1 of 5 sampled residents (Resident #2) who had 2 unresponsive episodes in less than 24 hours due to hypoglycemia which resulted in cardiac arrest and the placement of an external defibrillator vest.	{D 338}		

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{D 338}	Continued From page 9 Review of Resident #2's current FL2 dated 09/06/19 revealed diagnoses included hyperlipidemia, hypertension, atrial fibrillation, coronary artery disease, diabetes, and vitamin D deficiency. a. Review of the Emergency Medical Service (EMS) report for Resident #2 dated 06/09/20 revealed: -The facility called EMS at 9:04am. -The EMS unit was dispatched to the facility at 9:04am for hypoglycemia and arrived at the facility at 9:29am. -The paramedics found the resident lying on the couch in the common area. -The resident had a Glasgow Coma Scale (GCS is a tool that healthcare providers use to measure a person's level of consciousness). -Resident #2 was evaluated with a GSC of 8 out of a maximum of 15, he was diaphoretic (sweaty) and cool to the touch. -A GCS of 8 was documented as follows; Resident #2 responded to eye opening as a 2 (to pain only), verbal response was a 2 (incomprehensible speech), and motor response was a 4 (withdraws in response to pain). -Staff reported "we just got on at 7:00am, so we don't know what's going on". -The staff presented the following blood sugar readings to EMS as follows; BS 77mg/dl at 7:40am, 64 mg/dl at 8:00am, 113 mg/dl at 8:45am and 87 mg/dl at 8:58am. -The staff did not report a reason why they waited so long to call EMS, but stated that the resident's condition (GCS 8) was the same when they initially saw him this morning. -The resident had orange juice (OJ) around his mouth and on his shirt where the staff attempted to give prior to EMS arrival.	{D 338}		

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{D 338}	Continued From page 10 -IV access was obtained and the resident was given 150mg/dl of D10 (10% Dextrose) and his mental status improved. -Vital signs taken at 9:29am (on arrival) were as follows; GSC 8, heart rate 70, respiratory rate 14, blood pressure 160/70, oxygen status 95% on room air, and a blood sugar of 22. -Vital signs at 9:30am (after D10), were as follows GCS 15, heart rate 70, blood pressure 136/65, oxygen status 95% on room air and a blood sugar of 90. -The resident was transported to the hospital and arrived at 10:13am with a GCS of 15, alert and oriented. Review of the Emergency Department provider notes dated 06/09/20 at 10:20am revealed: -The chief complaint was documented as decreased blood sugar (symptomatic). -The history and physical was documented as a 70-year-old male brought in by EMS after being found unresponsive in his nursing facility this morning. The patient was initially alert this morning and received a dose of his insulin. He gets, Levemir, Januvia, Novolog and Glimepiride. He had not eaten since yesterday morning. He became unresponsive. It was documented that the patient had his glucose checked 4 times between 7:30am and 9:00am, and all of the values were between 70 - 115. However, when EMS arrived at 9:15am the patient's blood sugar was 22. The patient was now awake, alert, oriented and appropriate after receiving dextrose from EMS. -A point of care blood sugar was documented as 69. -A Complete Metabolic Panel was drawn and the result of the blood glucose was documented as 120. -A final diagnoses were documented as	{D 338}		

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hypoglycemia due to insulin and transient alteration of awareness.
-Resident #2 was discharged back to the facility at 2:00pm.

Review of a nurses note dated 06/09/20 at 11:03am.
-The entry was documented as a late entry completed by a medication aide (MA).
-Resident #2 was observed sitting in the dayroom unresponsive at 7:40am.
-The blood sugar was taken and it was 77.
-Resident #2 was given OJ with sugar to help bring his blood sugar back up.
-At 8:00am Resident #2's blood sugar was rechecked, and it was 64.
-At 8:45am a blood sugar was checked, and it was 113.
-The primary care physician (PCP) was called to be advised on the next procedure.
-The PCP advised to continue giving sweet OJ until resident blood sugar reached 180.
-At 8:58am recheck Resident #2's blood sugar and it was 87.
-The PCP was called again, and the PCP advised to send Resident #2 to the emergency room.
-At 9:11am the EMS arrived and checked Resident #2's blood sugar and it was 22.
-Resident #2 was given an IV and transported to the hospital for further evaluation.

Review of the Incident Report dated 06/09/20 revealed:
-The report was created at 10:55am by a MA.
-Resident #2 was found by a staff member in the day room, alone unresponsive, and sweating.
-The resident was documented as having a cognitive impairment/dementia.
-There were no injuries documented.
-First -aid was documented as not administered.

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{D 338}	Continued From page 12 -Resident #2's level of consciousness was documented as unresponsive. -Resident 2 was transported to the emergency room by EMS. -Resident #2 returned from the hospital on 06/09/20 with a diagnosis of Hypoglycemia and to follow up with PCP. Review of Resident #2's physician orders revealed: -On 01/29/20, an order to check a fingerstick blood sugar three times a day at 6:30am, 12:00pm and 5:00pm and to notify the physician if the blood sugar was greater than 400 or less than 70. -On 01/29/20, an order for Novolog Flexpen (is a fast acting insulin, used to treat diabetes, that begins to work within 5-10 minutes) 30 units with meals (prime pen with 2 units prior to each use) three times a day at 7:00am, 12:00pm and 5:00pm. -On 01/29/20, an order for glimepiride (a oral medication used to lower blood sugar) 4mg, 30 minutes before breakfast, at 6:30am. -On 01/29/20, an order for Levemir (is a long acting insulin used to lower blood sugar over a 24 hour period), (prime pen with 2 units prior to each use) 60 units two times a day at 8:30am and 8:00pm. -On 01/29/20, an order for Januvia (a medication used to lower blood sugar) 50mg every day at 8:30am. -On 05/07/20, the order for Novolog Flexpen was changed to 35 units with meals (prime pen with 2 units prior to each use) three times a day. Review of Resident #2's June 2020 electronic Medication Administration Record (eMAR) revealed: -The Glimepiride 4mg 30 minutes before	{D 338}		

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breakfast was documented as administered at 6:30am on 06/09/20.
-The Januvia 100mg every day was documented as not administered at 8:30am on 06/09/20 due to Resident #2 was at the hospital.
-The Levemir 60 units 2 times a day was documented as administered at 8:30pm on 06/09/20, and at 8:30am, not administered on 06/09/20 at 8:30am at hospital.
-The Novolog 35 units with meals was documented as administered at 6:30am, 11:30am, and 4:30pm, on 06/09/20 at 6:30am, not administered on 06/09/20 at 11:30am and 4:30pm resident at the ER.

Refer to telephone interview with the PCP on 06/12/20 at 3:03pm.

Refer to interview with a medication aide (MA) on 06/16/20 at 11:24am.

Refer to interview with a second MA on 06/16/20 at 12:00pm.

Refer to telephone interview with a third MA on 06/16/20 at 2:55pm.

Refer to telephone interview with a fourth MA on 06/16/20 at 4:19pm.

Refer to telephone interview with a fifth MA on 06/17/20 at 9:38am.

Refer to telephone interview with Resident #2's Pharmacist on 06/17/20 at 11:36am.

Refer to telephone interview with Resident #2 on 06/17/20 at 2:45pm.

b. Review of the Incident Report dated 06/10/20

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revealed:
-The event time was 4:54pm and created at 6:44pm by the Administrator.
-Resident #2 was found by a staff member in Resident #2's room, alone unresponsive.
-Resident #2's level of consciousness was documented as laying on the bed, unresponsive and sweating.
-Cardiopulmonary resuscitation (CPR) was initiated.
-At 4:55pm the vital signs were documented as follows; blood pressure 126-54, heart rate 45, oxygen saturation 95% on room air and blood sugar was 62 mg/dl.
-Resident 2 was transported to the emergency room by Emergency Medical Service (EMS) at 5:35pm.

Review of the (EMS) report for Resident #2 dated 06/10/20 revealed:
-The facility called EMS at 5:14pm.
-The unit was dispatched to the facility at 5:17pm for unconscious/fainting and arrived at the facility at 5:21pm.
-The paramedics found the resident lying supine, laying on the floor, agonal respirations (a breathing pattern used to describe gasping or struggle to breathe which is often a symptom of a severe medical emergency), and CPR in progress by the staff. Cardiac arrest due to hypoglycemia.
-A GCS of 3 (GCS is a tool that healthcare providers use to measure a person's level of consciousness and the normal value is 15) on arrival was documented as follows, Resident #2 responded to eye opening as a 1 (no response), verbal response was a 1 (no response), and motor response was a 1 (no response).
-Per report from the staff, Resident #2 was found unresponsive, pulseless and began CPR in his

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room and had been having issues with hypoglycemia.
-CPR was taken over by medic at 5:21pm and 100% oxygen supplied for Resident #2 at 15 liters via a bag valve mask.
-Resident initially pulseless and defibrillator pads were placed and Resident #2 was found to be in a narrow bradycardic rhythm (an abnormal heart rhythm less than 60) with multifocal PVCs (premature ventricular contractions are extra heartbeats that disrupt the regular rhythm of the heart).
-Vital signs, per cardiac monitor at 5:23pm were documented as follows; heart rate of 20, respirations of 12, blood pressure of 78/54, oxygen saturation of 100% on oxygen and a blood sugar of "lo" (less than 20 mg/dl). CPR stopped but resident was still in respiratory arrest.
-Mechanical pacing with 100% mechanical ventilation, intraosseous vascular access (venous access through the bone marrow for rapid fluid infusion during resuscitation), into the right leg, Dextrose 10%, 25 grams was pressure infused, GCS of 10, blood sugar of 74, spontaneous respirations now, pacer paused, cardiac rhythm now sinus with rhythm with multifocal PVC's, pacing continued, EGG performed and showed Left Ventricular hypertrophy (enlarged heart) with a left bundle branch block (a cardiac conduction abnormality), GCS now 14, and a blood sugar now at 188.
-Resident #2 was transported to the hospital at 5:38pm.
-Resident #2 arrived at the hospital at 5:51pm, his GCS increased to 15 and the resident unsure he ate but knew he had his insulin prior to the episode.

Telephone interview with a representative from Mecklenburg County Emergency Medical Service

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{D 338}	Continued From page 16 on 06/18/20 at 1:35pm revealed a "lo" on their glucose monitor indicates the blood sugar was less than 20 mg/dl. Review of the Emergency Department (ED) Provider Notes dated 06/10/20 at 6:06pm revealed: -The chief complaint was documented as follows; Resident #2 presented with decreased blood sugar (symptomatic), found down (unresponsive), Glasgow Coma Scale of 3. -There was clinical concern that they are unable to protect their airway or that they have an expected worsening clinical course based on exam or imaging findings, then intubation can be considered). Cardiopulmonary Resuscitation (CPR) on medic arrival. Blood sugar "LO" (20 mg/dl or less, normal blood sugar is 80-130mg/dl). ½ round of CPR heart rate 25, atrial fibrillation (abnormal heart rhythm), and sinus brady (heart rate lower than 60, normal heart rate 60-100). Medic paced (mechanical assistant to regulate heart rate) at 85 beats per minute. D10% administered (dextrose to raise blood glucose levels), 100% on assisted ventilation (breathing for patient). A repeat blood sugar 74, heart rate 63 with no pacer and a GCS of 15. -Resident #2 had a witnessed arrest, not breathing, found to have significant sinus bradycardia without pulses. -Resident #2 was in the emergency department less than 24 hours ago for the same event of symptomatic hypoglycemia and decreased responsiveness. -Resident #2's blood sugar on arrival to the hospital was 145mg/dl. -Resident #2 was on Levemir (a long acting insulin, which starts to work several hours after injection up to 24 hours), Novolog (fast acting	{D 338}		

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insulin, starts to work in 15 minutes after injection), Januvia (a medication used to treat hyperglycemia) and Glimepiride (a medication used with a proper diet to treat high blood sugars).
-The ED triage vitals were documented as follows; at 6:13pm the blood pressure was 140/82, heart rate was 62, respiratory rate was 18 and oxygen status was 98%.
-Blood was drawn and the blood glucose level was 82 and the HgB A1C was 8.6 (high, normal 4.8-5.6).
-An Electrocardiography (ECG) showed a heart rate of 60, and sinus rhythm with 1st degree AV block (a disease of the electrical conduction system of the heart), and abnormal ECG.
-Critical was necessary to treat or prevent imminent or life-threatening deterioration of the metabolic crisis and endocrine crisis.
-The diagnoses included, hypoglycemia secondary to sulfonylurea (medication used to lower blood sugar), accidental or unintentional, hypothermia, renal insufficiency and respiratory arrest.
-The diagnosis management comments included as follows; at 6:00pm he presented with respiratory arrest after profound hypoglycemia, sinus bradycardia which completely resolved with D10.
-It was likely Resident #2's oral hypoglycemic may be the culprit. Resident #2 may be over treated on his medication.
-Resident #2 was admitted to the Intensive Care Unit (ICU).

Review of a Cardiology consult note dated 06/10/20 at 3:36pm revealed:
-A noted profound hypoglycemia at the time of event, working diagnosis as a cause of patient's arrest. Reported sinus brady in the setting of

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profound hypoglycemia.
-Profound hypoglycemia at time of arrest the blood sugar was "lo" then 188 after D10, and then return of spontaneous circulation was achieved.
-A cardiac ejection fraction was 15-20%, 1st degree heart block.
-A recommendation for a candidacy for an ICD (internal cardiac defibrillator).

Review of the Hospitalist Admission Report dated 06/10/20 at 9:52pm revealed the assessment documented the following; recurrent/persistent hypoglycemia, in a patient currently on treatment including Amaryl and Levemir; second episode in 24 hours and transient respiratory arrest resolved.

Review of a facility's nurses note dated 06/10/20 at 6:53pm revealed:
-Staff reported to the Administrator, Resident #2 was unresponsive.
-The Administrator and the Resident Care Coordinator (RCC) entered Resident #2's bedroom and found Resident #2 unresponsive, pale in color, and skin was clammy.
-When obtaining vitals and performing a chest rub, Resident #2 remained unresponsive.
-Resident #2 stopped breathing and was transferred from the bed to the floor, CPR was started by the Administrator and continued until relieved by medics.
-The medics were able to resuscitate Resident #2 and transported Resident #2 to the hospital.
-The vital signs were documented as follows; blood pressure 126-54, heart rate 44, oxygen saturation 95% on room air and blood sugar was 62 mg/dl.

Review of the Cardiologist consult dated 06/11/20 revealed:

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{D 338}	Continued From page 19 -Resident #2 was an out of hospital cardiac arrest, with noted profound hypoglycemia ("low") at the time of event as a cause of Resident #2' cardiac arrest. -A history of known coronary artery disease and an ejection fraction on 15-20% (a percentage of the amount of the blood pumped out of the hearts lower chambers when your heart contracts, less than 50%, then your heart may not pump a sufficient amount of blood). -The plan included; Resident #2 presented with cardiac arrest secondary to hypoglycemia, an electrocardiogram shows ongoing ischemic cardiomyopathy with an ejection fraction of 15-20%, extensive coronary artery disease, would recommend an Implantable Cardioverter Defibrillator (ICD, is used if the ICD detects an abnormal heart rhythm, it will deliver an electric shock to restore the regular heartbeat). Review of Resident #2's hospital note dated 06/14/20 at 11:10am revealed: -The editor of the note was a Hospitalist. -The assessment and plan as follows; respiratory arrest due to hypoglycemia bradycardia, coronary artery disease, cardiology was following, stress test completed, follow up with cardiology as outpatient evaluation for an ICD and evaluation for a Life Vest (is a wearable Cardioverter defibrillator (WCD), a treatment option for patients at risk for sudden cardiac death). Review of Resident #2's hospital note dated 06/16/20 at 4:48pm revealed: -The editor of the note was a Internal Medicine physician. -The Life Vest WCD was placed on Resident #2. Review of Resident #2 June 2020 electronic Medication Administration Record (eMAR)	{D 338}		

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{D 338}	Continued From page 20 revealed: -The Glimepiride 4mg 30 minutes before breakfast was documented as administered at 6:30am on 06/10/20. -The Januvia 100mg every day was documented as administered at 8:30am on 06/10/20. -The Levemir 60 units 2 times a day was documented as administered at 8:30am on 06/10/20 on was not administered on 06/10/20 at 8:30pm at hospital. -The Novolog 35 units with meals was documented as administered at 6:30am, 11:30am, and 4:30pm, on 06/10/20 at 6:30am, 06/10/20 at 11:30am, and on 06/10/20 was not administered at 4:30pm resident at the ER. Refer to telephone interview with the PCP on 06/12/20 at 3:03pm. Refer to interview with a medication aide (MA) on 06/16/20 at 11:24am. Refer to interview with a second MA on 06/16/20 at 12:00pm. Refer to telephone interview with a third MA on 06/16/20 at 2:55pm. Refer to telephone interview with a fourth MA on 06/16/20 at 4:19pm. Refer to telephone interview with a fifth MA on 06/17/20 at 9:38am. Refer to telephone interview with Resident #2's Pharmacist on 06/17/20 at 11:36am. Refer to telephone interview with Resident #2 on 06/17/20 at 2:45pm.	{D 338}		

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{D 338}	Continued From page 21 Refer to interview with the Administrator on 06/16/20 at 12:22pm and 06/17/20 at 2:16pm. _____ Telephone interview with the PCP on 06/12/20 at 3:03pm revealed: -Novolog is a fast-acting insulin which means it peaks in 15-30 minutes and a resident must eat within 30 minutes or could have symptoms of hypoglycemia. -On 06/09/20, he received a call from a MA after 8:00am concerning Resident #2 was found unresponsive and his blood sugar was in the 70's-80's and OJ with sugar had been administered, Resident #2 normalized with a blood sugar of 113-120. -He told the MA to make sure the resident ate and continue to monitor. -He received a second call informing that the resident was unresponsive, blood sugar of 70, and he gave the order to send the resident to the hospital. -Resident #2's blood sugar was normally in the 200-300's and this was very unusual for him to be this low and considered this very serious for Resident #2. -If Resident #2 did not eat after receiving the short term insulin along with the long term insulin and his other two medications which lowered blood sugar, then his blood sugar could drop significantly low and Resident #2 could become lethargic and confused, which is even more dangerous for Resident #2 because he could go into insulin shock (too much insulin in the blood, causing the blood sugar to drop). -He expected the staff to make sure all residents receiving insulin eat after receiving insulin and if not continue to monitor for low blood sugar, i.e., sweating, confusion or unresponsiveness. -There were two reasons Resident #2 had the hypoglycemia episodes, 1) "possibly too much or	{D 338}		

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{D 338}	Continued From page 22 the wrong insulin" or 2) "receiving the insulin and not eating". Interview with a medication aide (MA) on 06/16/20 at 11:24am revealed: -She worked 7:00am to 7:00pm. -She started working at the facility 3 months ago and received the diabetic training upon hire. -Breakfast was served at 7:30am, lunch at 12:00pm and supper was at 5:00pm. -There was no documentation for the residents in the amount of meals and snacks consumed. -She administered Novolog insulin with meals which usually meant the resident would eat with in 30 minutes of the Novolog administration. -She was trained to check to see if a resident had eaten after receiving insulin but sometimes could not because of the medication pass. -On 06/10/20 at 8:30am, she administered Resident #2's Januvia and Levemir 60 units. -On 06/10/20, she checked on Resident #2 after breakfast because he was on a 14-day isolation after returning from the hospital. Resident #2 had eaten about 25% of his breakfast. -On 06/10/20 at 11:30am, Resident #2's blood sugar was fine, so she administered Resident #2's Novolog 35 units. -She did not see if he had eaten lunch because he did not require any more medications at that time. -On 06/10/20 at 4:30pm, she could not remember if she administered his 4:30 pm Novolog because she did not document it but found him in his room unresponsive around 5:15pm. She went and got the Administrator and there was no pulse, so the Administrator started CPR. -She documented on Resident #2 after he went to the hospital. Interview with a second MA on 06/16/20 at	{D 338}		

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{D 338}	Continued From page 23 12:00pm revealed: -She was new to the facility and worked 7:00am to 7:00pm. -She was trained in MA class how to give insulin, to check to make sure the resident eats after receiving insulin and the signs and symptoms of hypoglycemia (sweaty, thirsty and confusion). -She was trained in the diabetic training class as well. -A resident must eat with in 15-30 minutes after receiving insulin. -She did not always see the residents eat or make sure the residents had eaten because the medication pass took a long time. -She administered insulin to residents during 7:00am - 7:00pm shift. Telephone interview with a third MA on 06/16/20 at 2:55pm revealed: -She worked 7:00pm - 7:00am for 3 years now. -On 06/09/20 at 6:30am, she checked Resident #2's blood sugar and it was good (168), so she administered Resident #2's Novolog and Glimepiride. -Breakfast was at 8:00am and she left around 7:30am that morning and Resident #2 was sitting in the day room. -She recalled Resident #2 acting different, (staying in his room, tired and not eating) a few days prior (06/07/20 and 06/08/20). -She did not report Resident #2 acting different to the PCP. -On 06/08/20, she received report from another MA when she came on shift, Resident #2 was in his room a lot, not eating and was not feeling good and to keep an eye on him. -She did not know Resident #2 was sent to the hospital not long after she left work on 06/09/20. Telephone interview with a fourth MA on 06/16/20	{D 338}		

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{D 338}	Continued From page 24 at 4:19pm revealed: -She had been working at the facility since 03/01/20 on the 7:00pm to 7:00am shift. -She received the required diabetic training after she was hired to make sure a resident eats within 30 minutes after receiving insulin. -On 06/10/20, she administered Resident #2's Novolog and Glimepiride at 5:30am after checking his blood sugar and "it was ok to give the Novolog". -She could not recall what the blood sugar was, but knew that it was in the 200-300s. -She checked Resident #2's blood sugar at 5:30am when she worked because Resident #2 liked to have it done at that time and did not feel there was an issue with that because his blood sugar usually ran high. -She was told by the personal care aides Resident #2 was hot, not feeling good or eating over the weekend (06/06/20 and 06/07/20). -She did not report anything to the PCP. -On 06/10/20, when she checked his blood sugar and administered his insulin and Glimepiride, Resident #2 informed her that he had not been eating because it was so hot. She was not concerned because his blood sugar was as usual high. -She did not notify the PCP after Resident #2 reported to her about not eating. Telephone interview with a fifth MA on 06/17/20 at 9:38am revealed: -She worked 7:00am to 7:00pm shift the last 5 years. -She took the diabetic training when she was hired and yearly after that. -She was trained to make sure the residents ate after receiving insulin. -She checked to see if Resident #2 had eaten after receiving Novolog but did not recall the	{D 338}		

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{D 338}	Continued From page 25	{D 338}		

amount of food eaten.
-She was only to document how much a resident had eaten if the resident was a hospice resident.
-On 06/08/20 at 4:30pm, she checked Resident #2's blood sugar and administered the Novolog 35 units with meals to him in the hall but could not recall if Resident #2 was eating or had eaten.
-Before Resident #2 went to the hospital on 06/09/20 she administered his Levemir as ordered, and Januvia as ordered.
-The Novolog was administered as ordered except for on 06/08/20 she did not check Resident #2's blood sugar at 11:30am or administer his Novolog 35 units with meals because Resident #2 was not in the dining room.
- Around 6:30pm on 06/08/20, after she had administered his Novolog, she found him in his room, sweating (because no AC), and stated he did not want to eat, too tired. She thought he had eaten.
-She reported Resident #2 not feeling well and not eating to the next shift MA to keep eye on him.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 06/17/20 at 11:36am revealed:
-Resident #2 was on Januvia and Glimepiride to lower the blood sugar.
-Resident #2 was on Levemir, a long acting insulin, that would peak in 12 hours.
-Resident #2 was on Novolog, a short acting insulin, that would peak in 15-30 minutes and needs to eat within 15-30 minutes after receiving the insulin.
-If Resident #2 was taking all those medications and "not eating correctly at all", his blood sugar could drop into the 20's or if Resident #2 was taking the wrong amount of insulin, his blood sugar could drop into the 20's as well.

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{D 338}	Continued From page 26 Telephone interview with Resident #2 on 06/17/20 at 2:45pm revealed: -On 06/09/20, his blood sugar dropped low and he did not remember anything after sitting in the dayroom once he received his morning insulin and medications until he woke up being loaded into the ambulance. -He asked the EMS person what had happened. -He was told that his blood sugar was low, and they gave him something in his IV to make it better. -He had not eaten since breakfast the day before (06/08/20). -He had not been feeling good since the weekend. He felt hot, sweaty and tired and had not been eating but very little, if at all. -The AC was out at the facility, so he was really hot the last several days. -He told the MA over the weekend and the physician after the first visit to the hospital (06/10/20) he had not been eating but very little to not at all. Interview with the Administrator on 06/16/20 at 12:22pm and 06/17/20 at 2:16pm revealed: -All MAs received the diabetic training which included making sure residents eat after receiving insulin. -It was the policy and expectation after a MA administered insulin, the MA should check to see if the resident eats, and if not monitor for symptoms of low blood sugar such as sweating and confusion. -After a MA administered Novolog insulin, the resident was to eat within 15-30 minutes and no longer than that. -She did not know Resident #2 had not been eating after receiving his insulin. -Resident #2 received a long acting and a short	{D 338}		

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{D 338}	Continued From page 27 acting insulin as well as other diabetic medications. -Resident #2's blood sugar usually ran in the 200-300's and has not had an issue with hypoglycemia before._____ The facility failed to provide care and services which are adequate, appropriate, and in compliance with federal and state laws and rules and regulations for Resident #2 who continued to receive Levemir, Novolog, Glimepiride and Januvia and staff not ensuring resident was eating, which resulted in 2 unresponsive episodes in less than 24 hours secondary to hypoglycemia and the latter incident resulted in cardiac arrest and the placement of an external defibrillator vest. The facility's failure to provide care and services which were adequate, appropriate, and in compliance with federal and state laws and rules and regulations resulted serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 06/18/20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 18, 2020.	{D 338}		
{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	{D 358}		

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{D 358}	Continued From page 28 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure the rapid acting insulin was administered within the appropriate timeframe prior to meals and the correct dosage of insulin according to the physician's orders were administered and in accordance with the facility's policies for 1 of 5 residents (Resident #2). The findings are: Review of Resident #2's current FL2 dated 09/06/19 revealed: -Diagnoses included hyperlipidemia, hypertension, atrial fibrillation, coronary artery disease, diabetes, and vitamin D deficiency. -An order to check a fingerstick two times a day at 6:30am and 5:00pm and to notify the physician if the blood sugar was greater than 400 or less than 70. -An order for Novolog (is a fast acting insulin, used to treat diabetes, that begins to work within 5-10 minutes) Flexpen 25 units with meals (prime pen with 2 units prior to each use) three times a day at 7:00am, 12:00pm and 5:00pm. Review of Resident #2's physician orders revealed: -On 01/29/20 an order to check a fingerstick three times a day at 6:30am, 12:00pm and 5:00pm and to notify the physician if the blood sugar was greater than 400 or less than 70. -On 01/29/20 an order for Novolog Flexpen 30 units with meals (prime pen with 2 units prior to	{D 358}		

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each use) three times a day at 7:00am, 12:00pm and 5:00pm.
-On 05/07/20 an order for Novolog Flexpen 35 units with meals (prime pen with 2 units prior to each use) three times a day.

a. Review of Resident #2 May 2020 electronic Medication Administration Record (eMAR) revealed:
-An entry to check a fingerstick three times a day at 6:30am, 12:00pm and 5:00pm and to notify the physician if the blood sugar was greater than 400 or less than 70 documented as completed at 6:30am, 12:00pm, and 5:00pm 05/01/20 - 05/31/20.
-An entry for Novolog 30 units with meals (prime pen with 2 units prior to each use) three times a day, documented as administered 05/01/20 - 05/06/20 at 7:00am, 12:00pm and 5:00pm and 06/07/20 at 7:00am and 12:00pm.
-An entry for Novolog Flexpen 35 units with meals (prime pen with 2 units prior to each use) three times a day, 05/07/20 at 4:30pm, and 05/08/20 - 05/31/20 at 6:30am, 11:30am and 4:30pm.

Review of Resident #2 June 2020 electronic Medication Administration Record (eMAR) revealed:
-An entry to check a fingerstick three times a day at 6:30am, 12:00pm and 5:00pm and to notify the physician if the blood sugar was greater than 400 or less than 70 documented as completed 06/01/20 - 06/03/20 at 6:30am, 12:00pm, and 5:00pm.
-An entry for Novolog 35 units with meals (prime pen with 2 units prior to each use) three times a day, documented as administered 06/01/20 - 06/03/20 at 6:30am, 11:30am and 4:30pm.
-An entry for Novolog 35 units with meals (prime pen with 2 units prior to each use) three times a

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day, notify the physician if blood sugar is greater than 400 or less than 70 was documented as administered at 6:30am, 11:30am, and 4:30pm 06/04/20 - 06/08/20 at 6:30am, 06/08/20 at 11:30am resident unavailable, 06/08/20 at 4:30pm - 06/09/20 at 6:30am, 06/09/20 at 11:30am and 4:30pm resident at the ER, 06/10/20, 6:30am to 11:30am and 06/10/20 at 4:30pm resident was at hospital.

Review of Resident #2's Brand A glucometer's history on 06/24/20 revealed:
-Of the only history documented on the glucometer, 06/08/20 - 06/10/20, the blood sugar times were inconsistent compared to times documented on Resident #2's June 2020 eMAR.
-On 06/08/2,0 the recorded the blood sugar in the glucometer was at 5:15am instead of the eMAR documented time of 6:30am.
-On 06/09/20 the recorded the blood sugars in the glucometer were at 8:15am, 8:41am and 8:56am instead of the eMAR documented time of 6:30am.
-On 06/10/20 the recorded the blood sugar in the glucometer was at 5:15am instead of the eMAR documented time of 6:30am.

After review of Resident #2's Brand A glucometer's history and Resident #2's June eMAR, Resident #2 was receiving his blood sugar test and Novolog administration, 2 out of 3 times at 5:15am instead of the documented 6:30am time.

Telephone interview with the PCP on 06/12/20 at 3:03pm revealed:
-Novolog is a fast-acting insulin which means it peaks in 15-30 minutes.
-The Novolog was to be administered at 6:30am which was 30 minutes before the breakfast meal

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was to be served so Resident #2 would not have symptoms of hypoglycemia.
-He expected the staff to make sure all diabetics received Novolog no sooner than 30 minutes before each meal and to eat to help prevent hypoglycemia.
-Resident #2 was to have his blood sugar and Novolog administered at 6:30am, 11:30am and 5:00pm, and eating within 30 minutes of the administration of the insulin.
-If Resident #2 received the short term insulin along with the long term insulin at the incorrect dose or at an earlier time along with his other two medications which lowered blood sugar, then his blood sugar could drop significantly low and cause Resident #2 to go into insulin shock (too much insulin in the blood which causes low blood sugar) which could lead to death.

Interview with a medication aide (MA) on 06/16/20 at 11:24am revealed:
-She worked 7:00am to 7:00pm.
-She started working at the facility 3 months ago and received the diabetic training upon hire.
-Breakfast was served at 7:30am, lunch at 12:00pm and supper was at 5:00pm.
-She administered Novolog insulin with meals which usually meant the resident would need to eat within 30 minutes of the Novolog administration.
-She checked Resident #2's blood sugar and administered the insulin at the times specified on the eMAR.
-On 06/10/20 at 11:30am Resident #2's blood sugar was fine, so she administered Resident #2's Novolog 35 units and documented it on the eMAR.

Interview with a second MA on 06/16/20 at 12:00pm revealed:

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{D 358}	Continued From page 32 -She was new to the facility and worked 7:00am to 7:00pm. -She was trained in MA class how to give Novolog (15-30 minutes before the mea)l. -She was trained to follow the order in the eMAR. -She was trained in the diabetic training class as well. -She did not administer insulin to Resident #2. Telephone interview with a third MA on 06/16/20 at 2:55pm revealed: -She worked 7:00pm - 7:00am for 3 years now. -On 06/09/20 at 6:30am she checked Resident #2's blood sugar and it was good, so she administered Resident #2's Novolog and Glimepiride. -She documented the blood sugar and the insulin administration after it was completed. Telephone interview with a fourth MA on 06/16/20 at 4:19pm revealed: -She had been working at the facility since March 1, 2020 on 7:00pm to 7:00am. -She received the required diabetic training after she was hired. -On 06/10/20 she administered Resident #2's Novolog at 5:30am after checking his blood sugar and it was ok to give the Novolog. -She checked Resident #2's blood sugar at 5:30am when she worked because Resident #2 liked to have it done at that time and did not feel there was an issue with that because his blood sugar usually ran high. Telephone interview with Resident #2 on 06/17/20 at 2:45pm revealed he received his morning blood sugar checks and Novolog insulin usually around 5:00am to 5:15am because he "liked it at that time".	{D 358}		

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{D 358}	Continued From page 33 Interview with the Administrator on 06/16/20 at 12:22pm and 06/17/20 at 2:16pm revealed: -All MAs received the diabetic training which included following the orders from the physician related to administration times. -It was the policy and expectation the MA administered insulin at the correct times as ordered by the physician. -She did not know Resident #2 received his Novolog at 5:00am before the ordered 6:30am time. b. Review of Resident #2 May 2020 electronic Medication Administration Record (eMAR) revealed an order for Levemir (is a long acting insulin used to lower blood sugar over a 24 hour period) Flex Pen 60 units (prime pen with 2 units prior to each use) two times a day at 8:30am, and 8:00pm and documented as administered 05/01/20 - 05/31/20 at 8:30am and 8:00pm. Review of Resident #2 June 2020 electronic Medication Administration Record (eMAR) revealed: -An order for Levemir Flex Pen 60 units (prime pen with 2 units prior to each use) two times a day at 8:30am, and 8:00pm and was documented as administered at 8:30am and 8:30pm 06/01/20 - 06/08/20, at 8:00pm on 06/09/20, and at 8:30am on 06/10/20 (06/09/20 at 8:30am and 06/10/20 at 8:00pm at hospital). -On 06/11/20 - 06/16/20, Resident #2 was in the hospital and did not receive Levemir 60 units (prime pen with 2 units prior to each use) two times a day at 8:30am, and 8:00pm. Telephone interview with the facility pharmacy on 06/17/20 at 11:36am revealed: -Resident #2's current order for Levemir Flex touch pen, 60, (prime pen with 2 units prior to	{D 358}		

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each use) units twice a day.
-On 05/27/20, ten Levemir flex pens containing 60 units (prime pen with 2 units prior to each use) units for twice a day administration, was dispensed and delivered to the facility on 05/28/20 at 12:16am.
-The 05/27/20, Levemir would have been started on 05/28/20 at the 8:30am time.
-The 05/27/20, Levemir, if given according to the order, would have run out on 06/19/20.
-On 06/16/20, the pharmacy received a computer-generated request for refill and the facility was called to see if the Levemir was needed and was told the Levemir was out.
-On 06/16/20 10- Levemir flex pens containing 60 units (prime pen with 2 units prior to each use) units twice a day for administration, was dispensed and delivered to the facility on 06/16/20 at 11:52am.
-By his count the Levemir ran out 3 days early which could have been caused by administering the wrong amount of the Levemir.

After review of Resident #2's May 2020 and June 2020 eMAR and the telephone interview with the pharmacy, Resident #2 ran out of the Levemir 3 days early and did not receive 14 doses of Levemir from 06/11/20 - 06/16/20.

Observation via video conference of Resident #2's Levemir on 06/18/20 revealed there were 10-Levemir flex pens containing 60 units (prime pen with 2 units prior to each use) units for twice a day administration, with a dispense date of 06/16/20.

Telephone interview with Resident #2's PCP on 06/12/20 at 3:03pm revealed:
-He ordered Levemir 60 units two times a day t treat Resident #2's high blood sugars.

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-Resident #2's blood sugars usually ran in the 200-300's.
-Resident #2 had 2 hypoglycemic episodes on 06/09/20 and 06/10/20 and was hospitalized on 06/10/20 due to cardiac arrest brought on by hypoglycemia.
-Since Resident #2 ran out of the Levemir early, (14 doses) then it could mean the Levemir was given incorrectly and could have caused the hypoglycemic episodes which in turn could also caused the cardiac arrest.
-He expected the facility to administer the insulin as ordered.

Interview with a medication aide (MA) on 06/16/20 at 11:24am revealed:
-She worked 7:00am to 7:00pm.
-She started working at the facility 3 months ago and received the diabetic training upon hire.
-She administered the Levemir as ordered by the physician.
-On 06/09/20, 8:00am was the only time she was not able to administer Levemir because Resident #2 was at the hospital.

Telephone interview with a second MA on 06/16/20 at 2:55pm revealed:
-She worked 7:00pm - 7:00am for 3 years now.
-She administered the Levemir 60 units as ordered by the physician usually at 8:00pm to Resident #2.
-She did not miss any doses of the Levemir when she was working.

Telephone interview with a third MA on 06/16/20 at 4:19pm revealed:
-She had been working at the facility since March 1, 2020 on 7:00pm to 7:00am.
-She administered the Levemir to Resident #2 as ordered by the physician.

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{D 358}	Continued From page 36 -On 06/10/20, at 8:00pm the only time she was not able to administer Levemir because Resident #2 was at the hospital. Interview with the Administrator on 06/16/20 at 12:22pm and 06/17/20 at 2:16pm revealed: -All MAs received the diabetic training which included following the orders from the physician including the dosage amount. -It was the policy and expectation the MA administered insulin according to the physician's orders. _____ The facility failed to administer medications as ordered by a physician for Resident #2 who was prescribed Novolog, a fast acting insulin which peaks within 15-30 minutes, and administered an hour prior to the administration time and over two hours prior to eating, which increased the risk for hypoglycemia. Resident #2 was also ordered Levemir and administered the incorrect dose as evidenced by the Levemir running out 3 days too early which also increased the risk for hypoglycemia. The failure of the facility to administer insulin at the correct time and at the correct dose was detrimental to the health, safety and welfare of Resident #2 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 06/18/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 2, 2020.	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060149	A. BUILDING: _____ B. WING _____	R 06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

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{D912}	Continued From page 37 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 interviews and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to medication administration and personal care and supervision. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure the rapid acting insulin was administered within the appropriate timeframe prior to meals and the correct dosage of insulin according to the physician's orders were administered and in accordance with the facility's policies for 1 of 5 residents (Resident #2). [Refer to tag 0358, 10A NCAC 13F .1004(a) Medication Administration, (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to respond immediately and in accordance with the facility's established policy and procedures for 1 of 5 sampled residents (Resident #2) who was unresponsive due to a hypoglycemic episode which required immediate emergency services. [Refer to tag 0271, 10A NCAC 13F .0901c Personal Care and Supervision (Type A2 Violation)].	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060149	A. BUILDING: _____ B. WING _____	R 06/18/2020

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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
D914	Continued From page 38	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure residents were provided with the necessary care and services to maintain their physical health as related to resident rights. The findings are: Based on record reviews and interviews, the facility failed to provide care and services which are adequate, appropriate, and in compliance with Federal and State laws and rules and regulations for 1 of 5 sampled residents (Resident #2) who had 2 unresponsive episodes in less than 24 hours due to hypoglycemia which resulted in cardiac arrest and the placement of an external defibrillator vest. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights, (Type A1 Violation)].	D914		