STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041088	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF GREENSBORO	5125 MICHAUX ROAD GREENSBORO, NC 27410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey from 02/08/23 to 02/10/23.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 7 sampled residents (#4) related to errors with insulin administration. The findings are: 1. Review of Resident #4's current FL2 dated 02/06/23 revealed: -Diagnoses included type 2 diabetes mellitus, dementia and a history of traumatic brain injury. -There was an order for novolog insulin (a medication used to control high blood sugar levels) flexpen inject 9 units subcutaneously with meals, hold insulin if finger stick blood sugar (FSBS) < 100 or if resident not eating. Review of a signed physician's order dated 11/24/22 revealed there was an order for novolog insulin flexpen inject 9 units subcutaneously with	D 358		

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D 358	Continued From page 1	D 358		

meals, hold insulin if FSBS < 100 or if resident not eating.

Review of Resident #4's December 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for insulin aspart flexpen 9 units, hold if BS < 100 or if resident not eating with scheduled administration times of 9:00am, 12:00pm and 6:00pm.
-There was an entry for FSBS check blood sugar 3 times daily and record on eMAR, notify MD if FSBS < 60 or > 450 with scheduled administration times of 8:30am, 11:30am and 4:30pm.
-On 12/17/23, Resident #4's FSBS was documented as 81 and 9 units of insulin was documented as administered at 6:00pm when it should have been held.
-On 12/21/23, Resident #4's FSBS was documented as 91 and 9 units of insulin was documented as administered at 6:00pm when it should have been held.
-Resident #4's blood sugar ranged from 81-274.

Review of Resident #4's January 2023 eMAR revealed:
-There was an entry for insulin aspart flexpen 9 units, hold if BS < 100 or if resident not eating with scheduled administration times of 9:00am, 12:00pm and 6:00pm.
-There was an entry for FSBS check blood sugar 3 times daily and record on eMAR, notify MD if FSBS < 60 or > 450 with scheduled administration times of 8:30am, 11:30am and 4:30pm.
-On 01/02/23, Resident #4's FSBS was documented as 70 and 9 units of insulin was documented as administered at 6:00pm when it should have been held.

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-On 01/05/23, Resident #4's FSBS was documented as 77 and 9 units of insulin was documented as administered at 6:00pm when it should have been held.
-On 01/09/23, Resident #4's FSBS was documented as 60 and 9 units of insulin was documented as administered at 6:00pm when it should have been held.
-On 01/12/23, Resident #4's FSBS was documented as 98 and 9 units of insulin was documented as administered at 9:00am when it should have been held.
-Resident #4's BS ranged from 38-266.

Review of Resident #4's incident and accident report dated 01/12/23 at 11:00am revealed:
-Resident #4's FSBS was 98 around 7:30am.
-Resident #4 ate 100% of his breakfast at 8:00am.
-Insulin (9 units) was administered around 9:00am.
-The medication aide (MA) rechecked FSBS before lunch at 11am and FSBS result was 38.
-The MA gave Resident #4 orange juice and rechecked FSBS in 15 minutes, FSBS result was 99.
-Emergency Medical Services (EMS) was contacted and resident was given IV sugar, bringing FSBS result up to 246.
-Resident #4 was transported to the hospital for further evaluation.
-Resident #4's primary care provider (PCP), family member, and Department of Social Services (DSS) were all notified of the incident.

Observation of Resident #4's medications on hand on 02/10/23 at 10:58am revealed that there was one insulin aspart pre-filled syringe flexpen with an opened date of 01/20/23 available for administration.

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D 358	Continued From page 3 Telephone interview with Resident #4's PCP on 02/10/23 at 11:57am revealed: -She was contacted by the facility on 01/12/23 regarding the medication error of Resident #4's insulin. -She was not aware there were 2 errors in December 2022 and 3 other errors in January 2023 with Resident #4's insulin administration. -She expected the facility to administer medications as ordered, to include holding Resident #4's insulin according to parameters. -She was concerned about hypoglycemia and there was the potential for hypoglycemia on the days that Resident #4's insulin was administered when it should not have been. Interview with a MA on 02/09/23 at 2:50pm revealed: -She administered insulin to Resident #4 when his BS was 98 on 01/12/23. -She was under the impression the hold parameters for Resident #4's insulin was to hold if FSBS was below 90, but the hold parameters were to hold if FSBS was below 100. -Resident #4 was visibly sweating when she rechecked Resident #4's FSBS around 11:00am on 01/12/23. -Resident #4's FSBS was "in the 30's" when she rechecked it around 11:00am on 01/12/23. -EMS was contacted by the facility. -She informed Resident #4's PCP that she administered insulin to Resident #4 incorrectly on 01/12/23. -The Resident Care Director (RCD), Executive Director (ED), and Resident #4's family member were notified of Resident #4's low FSBS on 01/12/23. -Resident #4 was sent to the hospital and returned to the facility on 01/12/23.	D 358		

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D 358	Continued From page 4 Interview with a second MA on 02/09/23 at 3:02pm revealed: -She was aware that Resident #4's insulin should be held if his FSBS was below 100. -She documented insulin administration on the eMAR for Resident #4 when it should have been held on 01/02/23, 01/05/23 and 01/09/23. -She might have documented incorrectly on the eMAR and Resident #4 was not administered insulin on 01/02/23, 01/05/23 and 01/09/23. -She had checked with the Supervisor that worked those days and was told not to administer insulin to Resident #4. -She had not noticed Resident #4 having any signs or symptoms of hypoglycemia while she worked. Interview with the Special Care Unit Coordinator (SCUC) on 02/10/23 at 10:45am revealed: -She was aware Resident #4's insulin was supposed to be held when his FSBS was below 100. -The facility contacted EMS on 01/12/23 because Resident #4's FSBS was low. -EMS administered intravenous (IV) medication to Resident #4 for low blood sugar. -Resident #4 was sent to the hospital and returned to the facility on 01/12/23. -Resident #4's PCP was informed about Resident #4's low FSBS on 01/12/23. -The RCD conducted training for the MAs following the incident on 01/12/23. -She expected MAs to administer medications as ordered, including insulin. -She was not aware there were 2 errors in December 2022 and 3 other errors in January 2023 with Resident #4's insulin administration prior to 01/12/23.	D 358		

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D 358	Continued From page 5 Interview with the RCD on 02/10/23 at 12:30pm revealed: -She was not aware Resident #4 was administered insulin when it should have been held on 12/17/22, 12/21/22, 01/02/23, 01/05/23 and 01/09/23. -She expected MAs to administer medications as ordered, including holding insulin when it should be held. -The facility's contracted pharmacy performed eMAR and medication cart audits. -Two nurses associated with the facility's contracted pharmacy audited the eMARs and medication carts monthly and a pharmacist from the facility's contracted pharmacy audited quarterly. -She had conducted a training with the MAs and supervisors on 01/05/23 in response to a Pharmacist eMAR audit on 01/03/23 to address insulin and medication administration. Interview with the ED on 02/10/23 at 12:48pm revealed: -She was not aware Resident #4 was administered insulin when it should have been held on 12/17/22, 12/21/22, 01/02/23, 01/05/23, 01/09/23. -She expected MAs to hold insulin if it should be held according to parameters and MAs were responsible to administer medications as ordered. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable. Attempted telephone interview with Resident #4's family member on 02/10/23 at 1:07pm unsuccessful.	D 358		