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
	HAL013044	A. BUILDING: ______ B. WING ______	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	**160 WARREN C. COLEMAN BLVD.** **CONCORD, NC 28027**

(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 Cabarrus County Department of Social Services conducted an annual survey on 02/28/23 to 03/02/23.	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: Based on interviews and record reviews, the facility failed to notify a primary care provider (PCP) for 1 of 5 sampled residents related to an order to check finger stick blood sugars (FSBS) and report FSBS less than 65 or greater than 401. The findings are: Review of Resident #1's current FL2 dated 10/24/22 revealed: -Diagnoses included diabetes mellitus type 1, schizophrenia, osteopenia, and bipolar disease. -Resident #1 was intermittently disoriented. Review of Resident #1's signed physician orders dated 10/19/22 revealed an order to check FSBS before meals and at bedtime, notify PCP for FSBS <65 or >450. Review of Resident #1's physician's order dated 11/14/22 revealed an order for Novolog (a fast-acting insulin used to treat high blood sugar) 100 units/ml Flex pen subcutaneously (SQ) , check FSBS before each meal and administer sliding scale insulin (SSI) based on the following	D 273	SIC will notify physician of any significant change in condition of resident and/or report out of parameter FSBS to physician immediately. Administrator/RCC will audit all orders once per week x4 weeks, then once per month ongoing to assure any orders needing to be referred to outside agencies or providers are completed.	4/17/2023

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Mark Spaur TITLE Administrator (X6) DATE 4/10/23

Reviewwed and acknowledged on 04/10/23 by DMS

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D 273	Continued From page 1 FSBS: 201-250=2units, 251-300=4units, 301-350=6units, 351-400=8units, if FSBS>401=10units and call PCP, scheduled for 6:30am, 10:30am, and 4:30pm. Review of Resident #1's January 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check FSBS before meals and at bedtime, notify the PCP for FSBS <65 or >450. -There was an entry for Novolog 100 unit/ml Flex Pen SQ, check FSBS before each meal and administer SSI based on the following FSBS: 201-250=2units, 251-300=4units, 301-350=6units, 351-400=8units, if FSBS>401=10units and call PCP, scheduled for 6:30am, 10:30am, and 4:30pm. -There was no documentation the PCP was notified on 01/02/23 at 6:30am when the resident's FSBS was 479. -There was no documentation the PCP was notified on 01/16/23 at 8:00pm when the resident's FSBS was 456. Review of Resident #1's February 2023 eMAR revealed: -There was an entry to check FSBS before meals and at bedtime, notify the PCP for FSBS <65 or >450. -There was an entry for Novolog 100 unit/ml Flex Pen SQ, check FSBS before each meal and administer SSI based on the following FSBS: 201-250=2units, 251-300=4units, 301-350=6units, 351-400=8units, if FSBS>401=10units and call PCP, scheduled for 6:30am, 10:30am, and 4:30pm. -There was documentation the PCP was notified on 02/01/23 at 6:30am of 53 and 02/15/23 at 6:30am when the resident's FSBS was 53.	D 273		

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D 273	Continued From page 2	D 273		

-There was no documentation the PCP was notified 02/14/23 at 4:30pm when the resident's FSBS was 413.
There was no documentation the PCP was notified when the resident's FSBS was 58.

Review of Resident #1's January 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check FSBS before meals and at bedtime, notify the PCP for FSBS <65 or >450.
-There was an entry for Novolog 100 units/ml Flex pen, check FSBS at bedtime and administer SSI based on the following FSBS: 301-350=2units, 351-400=4units, FSBS >401=6units and call PCP scheduled for 8:00pm.
-There was no PCP notification of FSBS >401 on 01/16/23 at 8:00pm of 456.
Review of Resident #1's record on 03/01/23 revealed there was no documentation of any PCP notification of FSBS <65 or >401 for the months of January and February.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 03/02/23 at 9:36am revealed:
-An elevated blood sugar >401 could cause vomiting, increased thirst, blurred vision and fatigue.
-A low blood sugar <65 could cause blurred vision, difficulty concentration, confusion, slurred speech, numbness, and drowsiness.

Telephone interview with a Registered Nurse (RN) at Resident #1's Endocrinologist's office on 03/01/ at 3:35pm revealed:
-Resident #1 was seen on 11/09/22.
-Resident #1 last hemoglobin A1c was 8.7% on 11/09/22.

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D 273	Continued From page 3 -There were no notifications received of Resident #1's FSBS less than 65 or greater than 401 in January and February 2023. Telephone interview with a RN at Resident #1's PCP's office on 03/03/23 at 9:06am revealed: -The Endocrinologist followed Resident #1 for all diabetic needs. -There were no notifications received of Resident #1's FSBS <65 or >401 in January and February 2023. -The facility should notify the Endocrinologist of FSBS <65 or >401 for possible adjustment of insulin. Interview with a medication aide (MA) on 03/01/23 at 2:15pm revealed: -He knew to call Resident #1's PCP if FSBS was less than 65 or greater than 401. -He called Resident #1's PCP when his FSBS was low but did not document it. -He did not receive a call back from the PCP and did not follow up after no response was received. Interview with a second MA on 03/02/23 at 9:16am revealed: -She knew to call Resident #1's PCP if his FSBS was was than 65 or greater than 401. -She had not needed to call the PCP office in over two months for Resident #1's FSBS. -She did not recall Resident #1 having a FSBS of 479 on 01/02/23. Interview with a third MA on 03/02/23 at 9:45am revealed: -She knew to call the PCP if Resident #1's FSBS >401. -She left a message for Resident #1's PCP on 02/14/23 at 4:30pm when his FSBS was 413. -She called a total of three times with no	D 273		

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response and notified the Resident Assurance Coordinator (RAC).
-She did not document when she called the PCP on 02/14/23.

Interview with Resident Care Coordinator (RCC) on 03/02/23 at 9:55am revealed:
-She expected the MAs to call the PCP if Resident #1's FSBS was less than 65 or or greater than 401.
-If the MAs left messages for the PCP they were expected to call back again within 30 minutes and notify the RAC and/or the RCC if the PCP hand called back so the RAC/RCC could attempt to call the PCP.
-The RACs were responsible for completing monthly eMAR audits, including FSBS out of parameters and were to report any findings to the RCC.
-She did not recall being notified of PCP not being notified of FSBS less than 65 or greater than 401.

Interview with Administrator on 03/02/23 at 12:40pm revealed:
-He expected staff to follow orders and to notify the PCP of Resident #1's FSBS less than 65 or greater than 401.
-He expected staff to notify the RAC or RCC if PCP had not returned their call.
-He expected staff to call 911 if PCP had not returned call within 15 minutes.
-The RACs were responsible for completing monthly eMAR audits, including FSBS out of parameters and were to report any findings to the RCC.
-He expected staff to document in the eMAR exceptions or in Resident's chart.

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D 358	Continued From page 5	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: Based on interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 2 sampled residents (Resident #1) including a fast-acting insulin that was not administered correctly to treat high blood sugars. The findings are: Review of Resident #1's current FL2 dated 10/24/22 revealed: -Diagnoses included diabetes mellitus type 1, schizophrenia, osteopenia, and bipolar disease. -Resident #1 was intermittently disorientated. Review of Resident #1's physician's order dated 11/14/22 revealed an order for Novolog (a fast-acting insulin used to treat high blood sugar) 100 units/ml Flex pen subcutaneously (SQ), check finger stick blood sugar (FSBS) before each meal and administer sliding scale insulin (SSI) based on the following FSBS: 201-250=2units, 251-300=4units, 301-350=6units, 351-400=8units, FSBS>401=10units and call Primary Care Provider (PCP), scheduled for 6:30am, 10:30am, and 4:30pm.	D 358	Medication Aides will be re-trained by RN on administration of medications including Diabetic medications. RCC/Designee will audit MARs to ensure they match all current orders. RCC/Designee will audit MARs to ensure they match all current orders Administrator/Designee will observe a minimum of 2 medication passes weekly x4, will observe a minimum of 3 medication passes monthly x3 and then randomly thereafter.	4/17/2023

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D 358	Continued From page 6	D 358		

Review of Resident #1's January 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Novolog 100 unit/ml Flex Pen, check FSBS before each meal and administer SSI based on the following FSBS: 201-250=2units, 251-300=4units, 301-350=6units, 351-400=8units, FSBS>401=10units and call PCP, scheduled for 6:30am, 10:30am, and 4:30pm.
-On 01/14/23 at 6:30am, there was documentation the FSBS was 385 and Novolog 100units/ml six units was administered.
-On 01/21/23 at 10:30am, there was documentation the FSBS was 206 and Novolog 100units/ml no units was administered.
-On 01/25/23 at 6:30am, there was documentation the FSBS was 311 and Novolog 100units/ml six units was administered. .
-The FSBS range was 53-479.
-The Novolog was documented as administered incorrectly 3 out of 93 opportunities.

Review of Resident #1's February 2023 eMAR revealed:
-There was an entry for Novolog 100 unit/ml Flex Pen, check FSBS before each meal and administer SSI based on the following FSBS: 201-250=2units, 251-300=4units, 301-350=6units, 351-400=8units, FSBS>401=10units and call PCP, scheduled for 6:30am, 10:30am, and 4:30pm.
-On 02/24/23 at 10:30am, there was documentation the FSBS was 218 and Novolog 100units/ml two units was administered. .
-The FSBS range was 53-413.
-The Novolog was documented as administered incorrectly 1 out of 81 opportunities.

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D 358	Continued From page 7	D 358		

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 03/02/23 at 9:36am revealed if the resident received a decreased dose of insulin, the FSBS could continue to increase resulting in nausea, hyperglycemia, headache, increased blood pressure, increased thirst, and blurred vision.

Interview with a first shift medication aide (MA) on 03/02/23 at 9:45am revealed:
-She was responsible for documenting the FSBS readings, the amount of insulin administered to Resident #1 and the site insulin was administered on a designated place on the eMAR.
-On 01/21/23 at 10:30am she did not know she incorrectly read Resident #1's physician orders which did require 2units to be administered for FSBS of 206.
-On 02/25/23 at 10:30am she did not know she incorrectly read Resident #1's physician orders which did require 2units to be administered for FSBS of 218.

Interview with a third shift MA on 03/02/23 at 10:36am revealed:
-He was responsible for documenting the FSBS readings, amount of insulin administered to Resident #1 and the site where insulin was administered on a designated place on the MAR.
-On 01/14/23 at 6:30am he did not know he incorrectly read Resident #1's physician orders which did require 8units to be administered.

Telephone interview with a MA on 03/02/23 at 9:16am revealed:
-She had received training on insulin administration prior to being allowed to administer medications.
-She was responsible for documenting the FSBS readings, the amount of insulin administered to

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D 358	Continued From page 8 Resident #1 and the site insulin was administered on a designated place on the eMAR. -On 01/25/23 at 6:30am she he did not know she incorrectly read Resident #1's physician orders which did require 6units to be administered. Interview with the Resident Care Coordinator (RCC) on 03/02/23 at 9:55am revealed: -She expected the MAs to administer medications as ordered. -She did not know the MAs had administered the incorrect amount of insulin to Resident #1. -The Resident Assurance Coordinators (RACs) were responsible for completing monthly eMAR audits, including FSBS and insulin administration and were to report any findings to the RCC. -If a resident had been incorrectly administered a medication, she expected the MA to notify the residents Primary Care Provider (PCP) immediately. Interview with the Administrator on 03/02/23 at 1:40pm revealed: -He expected the MAs to administer medications as ordered. -He did not know MAs had administered the incorrect amount of insulin to Resident #1. -The RCC was responsible for eMAR audits at least monthly. -The RCC was responsible for handling issues involving clinical concerns.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:	D 367		

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D 367	Continued From page 9 (1) resident's name; (2) name of the medication or treatment order;. (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medication administration records were complete and accurate for 1 of 2 residents sampled (Resident #1) related to not documenting the amount of sliding scale insulin (SSI) was administered. Review of Resident #1's current FL2 dated 10/24/22 revealed: -Diagnoses included diabetes mellitus type 1, schizophrenia, osteopenia, and bipolar disease. -Resident #1 was intermittently disoriented. Review of Resident #1's physician's order dated 11/14/22 revealed an order for Novolog (a fast-acting insulin used to treat high blood sugar) 100 units/ml Flex pen subcutaneously (SQ) check (finger stick blood sugar) FSBS at bedtime and administer SSI based on the following FSBS:	D 367	Medication Aides were retrained on procedures for documenting FSBS readings. RCC reviewed MARs to ensure there is space to document FSBS readings. Administrator/RCC will audit MARs to ensure Medication Aides are documenting FSBS at least monthly.	4/17/2023

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D 367	Continued From page 10 301-350=2units, 351-400=4units, FSBS >401=6units and call Primary Care Provider (PCP) scheduled for 8:00pm. Review of Resident #1's January 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novolog 100 units/ml Flex pen SQ, check FSBS at bedtime and administer SSI based on the following FSBS: 301-350=2units, 351-400=4units, FSBS >401=6units and call PCP scheduled for 8:00pm. -On 01/03/23, the FSBS was documented as 327 and there was no documentation Novolog was administered. -On 01/07/23, FSBS was documented as 393 and there was no documentation Novolog was administered. -On 01/12/23, FSBS was documented as 301 and there was no documentation Novolog was administered. -On 01/13/23, FSBS was documented as 315 and there was no documentation Novolog was administered. -On 01/16/23, FSBS was documented as 456 and there was no documentation Novolog was administered. -On 01/31/23, FSBS was documented as 355 and there was no documentation Novolog was administered. -There was no place on the eMAR to document units of Novolog SSI administered for six occurrences where Novolog was required. Review of Resident #1's February 2023 eMAR revealed: -There was an entry for Novolog 100 units/ml Flex pen SQ, check FSBS at bedtime and administer SSI based on the following FSBS: 301-350=2units, 351-400=4units, FSBS	D 367		

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D 367	Continued From page 11 >401=6units and call PCP scheduled for 8:00pm. -On 02/02/23, FSBS was documented as 369 and there was no documentation Novolog was administered. -On 02/12/23, FSBS was documented as 304 and there was no documentation Novolog was administered. -On 02/13/23, FSBS was documented as 358 and there was no documentation Novolog was administered. -On 02/15/23, FSBS was documented as 302 and there was no documentation Novolog was administered. -On 02/17/23, FSBS was documented as 332 and there was no documentation Novolog was administered. -On 02/20/23, FSBS was documented as 334 and there was no documentation Novolog was administered. -On 02/23/23, FSBS was documented as 317 and there was no documentation Novolog was administered. -On 02/25/23, FSBS of 301, 2units were required, no documentation of insulin units administered. -There was no place on the eMAR to document units of Novolog SSI administered for eight occurrences where Novolog was required. Review of Resident #1's care notes for January and February 2023 revealed there was no documentation NovoLog was administered on 01/03/23, 01/07/23, 01/12/23, 01/13/23, 01/16/23, 01/31/23, 02/02/23, 02/15/23, 02/17/23, 02/20/23, 02/23/23 and 02/25/23. Telephone interview with a medication aide (MA) on 03/02/23 at 9:16am revealed: -She was responsible for documenting the FSBS readings, the amount of SSI insulin administered to Resident #1 and the site insulin was	D 367		

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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 367	Continued From page 12	D 367		

administered on a designated place on the eMAR.
-She knew Resident #1's eMAR did not have a place to document number of units administered.
-She did administer Novolog to Resident #1 when required but did not document number of units administered.
-She should have documented number of units administered in Resident #1's care notes.
-She did not notify anyone that there was no place to document the number of units administered on the eMAR.

Interview with a third MA on 03/02/23 at 10:36am revealed:
-He was responsible for documenting the FSBS readings, amount of insulin administered to Resident #1 and the site insulin was administered on a designated place on the eMAR.
-He did administer Novolog to Resident #1 when required but did not document number of units administered.
-He did not notify anyone that there was not a place to document the number of units administered on the eMAR.
-He should have documented the number of units administered in Resident #1's care notes.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 03/01/23 at 9:53am revealed:
-The facility was responsible for faxing the pharmacy orders to add on the eMAR.
-The pharmacy sent orders to the facility for the facility to review and accept.
-Once the facility accepted orders, the pharmacy added on the eMAR.
-The pharmacy missed adding a place on the eMAR to document the number of units administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: ______ B. WING ______	03/03/2023

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D 367	Continued From page 13 -The facility accepted Resident #1's orders on 11/15/22. -The facility had access to add a place to document units given on the eMAR. Interview with the Resident Care Coordinator (RCC) on 03/02/23 at 9:55am revealed: -She expected the MAs to administer medications as ordered. -She expected the MAs to document number of units of insulin administered to Resident #1 along with FSBS and site where insulin was administered. -She did not know the MAs were not documenting the number of units given to Resident #1. -She did not know there was not a place to document the number of units given on Resident #1's eMAR. -The MAs should have reported there was no place to document the number of units to Resident #1. -The MAs should have documented the number of units administered in Resident #1's care notes. -The Resident Assurance Coordinator (RACs) were responsible for completing monthly eMAR audits, including FSBS and insulin administration and are to report any findings to the RCC. Interview with the Administrator on 03/02/23 at 1:40pm revealed: -He expected the MAs to administer medications as ordered. -He did not know MAs were not documenting the number of units SSI administered to Resident #1. -The MAs should have reported there was no place to document the number of units administered to Resident #1. -The RCC was responsible for monthly eMAR audits.	D 367		