STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL036035	A. BUILDING: _____ B. WING _____	04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALDEN POND CARE HOME	101 OLDE COACH LANE CHERRYVILLE, NC 28021

(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
C 000	Initial Comments The Adult Care Licensure Section and the Gaston County DSS conducted an annual survey on 04/04/23.	C 000		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to clarify medication orders for 1 of 3 residents (#1) related to an order for long-acting insulin. The findings are: Review of Resident #1's current FL2 dated 03/21/23 revealed: -Diagnoses included diabetes mellitus and hypertension. -There was an order for Levemir (a long acting insulin that is used to treat type 1 and type 2 diabetes) 38 units before bedtime.	C 315		

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C 315	Continued From page 1 Review of Resident #1's physician's visit note signed on 03/15/23 revealed an order for detemir (the generic equivalent to Levemir) 40 units before bedtime. Review of Resident #1's March 2023 medication administration record (MAR) revealed: -An entry for Levemir Flextouch 100 units, inject 38 units at bedtime. -Levemir was documented as administered from 03/01/23 through 03/31/23. Review of Resident #1's March 2023 8:00pm finger stick blood sugar (FSBS) log revealed: -Resident #1's 8:00pm blood sugars and the amount of insulin administered were documented. -Levemir 38 units subcutaneous (SQ) before bedtime was typed at the bottom of the page. -The "38" units was crossed out and 40 units was handwritten at the bottom of the page. -From 03/01/23 through 03/15/23 it was documented that 38 units of insulin were administered. -From 03/16/23 through 03/31/23 it was documented that 40 units of insulin were administered. Review of Resident #1's April 2023 MAR revealed: -An entry for Levemir Flextouch 100 units, inject 38 units at bedtime. -Levemir was documented as administered from 04/01/23 through 04/03/23. Review of Resident #1's April 2023 8:00pm FSBS log revealed: -Resident #1's 8:00pm blood sugars and the amount of insulin administered were	C 315		

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C 315	Continued From page 2	C 315		

documented.
-Levemir 38 units SQ before bedtime was typed at the bottom of the page.
- The "38" units was crossed out and 40 units was written at the bottom of the page.
-From 04/01/23 through 04/03/23 was documented that 40 units of insulin were administered.

Observation of Resident #1's medications on hand on 04/04/23 revealed a bottle of detemir insulin with a label that stated inject 36 units before bedtime.

Telephone interview with a pharmacy representative at the facility's contracted pharmacy on 04/04/23 at 3:30pm revealed:
-The facility used paper MARs and the pharmacy entered the medications on the MAR.
-The pharmacy sent MARs to the facility every month.
-The pharmacy had an order dated 03/17/23 for detemir 40 units before bedtime for Resident #1.
-The pharmacy did not have any orders dated 03/21/23 for Resident #1.
-The pharmacy made Resident #1's MARs but she received her medication from a different pharmacy.

Interview with the Supervisor in Charge (SIC) on 04/04/23 at 1:52pm revealed:
-She sent Resident #1's physician's notes to the pharmacy to update Resident #1's MARs.
-She did not send Resident #1's FL2 to the pharmacy since the Administrator oversaw the FL2s.
-She compared Resident #1's April 2023 MAR and April 2023 FSBS log to the orders on Resident #1's physician's note dated 03/15/23 to ensure accuracy.

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C 315	Continued From page 3 -She did not look at Resident #1's FL2 dated 03/21/23 since she knew Resident #1 saw the physician recently. -She was not aware the order for Resident #1's detemir on the FL2 dated 03/21/23 did not match the physician's orders dated 03/15/23. Interview with the Administrator on 04/04/23 at 2:30pm revealed: -Resident #1 saw an outside physician but had her FL2 signed by the facility's contracted physician. -On 03/21/23, she filled out Resident #1's FL2 and gave it to the contracted physician to sign. -She thought she sent Resident #1's FL2 dated 03/21/23 to the pharmacy. -She and the SIC audited the MAR against the medication orders toward the end of each month. -She did not realize Resident #1's order for detemir on the FL2 did not match her outside physician's orders dated 03/15/23. -She and the SIC were responsible for clarifying orders. Attempted telephone interview with Resident #1's physician on 04/04/23 at 4:20pm was unsuccessful.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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	C 330		

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C 330	Continued From page 4 and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered by a physician for 1 of 3 sampled residents (#1) related to a short-acting insulin. The findings are: Review of Resident #1's current FL2 dated 03/21/23 revealed: -Diagnoses included diabetes mellitus and hypertension. -An order for Novolog 31 units before lunch with correction premeal reading lunch if finger stick blood sugar (FSBS) was 150-200= 4 units, over 201= 5 units, reduce by 12 units if under 90. -An order for Novolog 20 units before supper with correction premeal reading supper if FSBS was 150-200= 4 units, over 201= 5 units, reduce by 12 units if under 90. a. Review of Resident #1's FL2 dated 02/01/23 revealed Novolog 31 units before lunch, correction dose if FSBS was 150-201= 4 units, over 201= 14 units, less than 90 reduce insulin by 12 units. Review of Resident #1's physician's verbal order dated 02/15/23 revealed an order for a correction dose of Novolog, before lunch if FSBS was 150-200= 4 units, over 201= 6 units, less than 90 reduce insulin by 12 units. Review of Resident #1's March 2023 MAR revealed: -An entry for Novolog 100 units/mL vial inject 31	C 330		

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C 330	Continued From page 5	C 330		

units once before lunch, premeal FSBS readings 150-200 add 4 extra units, >200 add 6 extra units, <90 reduce by 12 units scheduled for 12:00pm.
-There was no documentation of Resident #1's FSBS or the amount of Novolog administered there was a handwritten entry that stated, "documented on FSBS log".

Review of Resident #1's March 2023 11:30am FSBS log revealed:
-Resident #1's FSBS at 11:30am and the amount of insulin administered were documented from 03/01/23 through 03/31/23.
-A typed entry for Novolog 31 units before lunch reduce by 4 units if FSBS under 90.
-There was a handwritten entry dated 03/16/23, reduce by 12 units if FSBS under 90.
-There was one occurrence when Resident #1's FSBS was under 90.
-On 03/29/23 FSBS was 71 and 20 units of insulin were documented as administered.

Refer to interview with Resident #1 on 04/04/23 at 4:05pm.

Refer to interview with the Supervisor in Charge (SIC) on 04/04/23 at 3:15pm.

Refer to telephone interview with a Pharmacist at the facility's contracted pharmacy on 04/04/23 at 3:45pm.

Refer to interview with the Administrator on 04/04/23 at 4:15pm.

b. Review of Resident #1's FL2 dated 02/01/23 revealed Novolog 20 units before supper, correction dose if FSBS was 150-201= 4 units, over 201= 14 units, less than 90 reduce insulin by 12 units.

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C 330	Continued From page 6 Review of Resident #1's physician's verbal order dated 02/15/23 revealed an order for a correction dose of Novolog, before supper if FSBS was 150-200= 4 units, over 201= 6 units, less than 90 reduce insulin by 12 units. Review of Resident #1's February 2023 MAR revealed: -An entry for Novolog 100 units/mL vial inject 20 units once before supper, premeal FSBS readings 150-200 add 4 extra units, >200 add 14 extra units, <90 reduce by 12 units scheduled for 4:30pm. -There was no documentation of Resident #1's FSBS or the amount of Novolog administered there was a handwritten entry that stated, "documented on FSBS log". Review of Resident #1's February 2023 4:30pm FSBS log revealed: -Resident #1's FSBS at 4:30pm and the amount of insulin administered were documented from 02/01/23 through 02/28/23. -A typed entry for Novolog 22 units before supper reduce by 4 units if FSBS under 90. -A handwritten entry dated 01/12/23 Novolog 20 units before supper. -There was one occurrence when Resident #1's FSBS was under 90. -On 02/13/23 Resident #1's FSBS was 72 and 16 units of insulin were documented as administered. Review of Resident #1's March 2023 MAR revealed: -An entry for Novolog 100 units/mL vial 20 units once before supper, premeal FSBS readings 150-200 add 4 extra units, >200 add 6 extra units, <90 reduce by 12 units scheduled for 4:30pm.	C 330		

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C 330	Continued From page 7 -There was no documentation of Resident #1's FSBS or the amount of Novolog administered there was a handwritten entry that stated, "documented on FSBS log". Review of Resident #1's March 2023 4:30pm FSBS log revealed: -A typed entry for Novolog units/mL vial 20 units before supper reduce by 4 units if FSBS under 90. -There was a handwritten entry dated 03/16/23, reduce by 12 units if FSBS under 90. -There were three occurrences when Resident #1's FSBS was under 90. -On 03/06/23, Resident #1's FSBS was 68 and 16 units of insulin were documented as administered. -On 03/09/23, Resident #1's FSBS was 87 and 16 units were documented as administered. -On 03/13/23, Resident #1's FSBS was 74 and 16 units were documented as administered. -Resident #1's FSBS at 4:30pm and the amounts of insulin administered were documented from 03/01/23 through 03/31/23. Refer to interview with Resident #1 on 04/04/23 at 4:05pm. Refer to interview with the SIC on 04/04/23 at 3:15pm. Refer to telephone interview with a Pharmacist at the facility's contracted pharmacy on 04/04/23 at 3:45pm. Refer to interview with the Administrator on 04/04/23 at 4:15pm. Attempted telephone interview with Resident #1's physician on 04/04/23 at 4:20pm was	C 330		

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C 330	Continued From page 8 unsuccessful. _____ Interview with Resident #1 on 04/04/23 at 4:05pm revealed she received insulin before meals, but she was not sure how much insulin she was supposed to receive. Interview with the SIC on 04/04/23 at 3:15pm revealed: -She and the other SIC wrote Resident #1's new insulin orders on the FSBS log when the order changed. -She only edited the current month's FSBS log since Resident #1's insulin orders have changed frequently. -She did not realize Resident #1 was supposed have the before lunch and supper insulin reduced by 12 units for a FSBS under 90 until she received Resident #1's physician's orders signed 03/15/23. -She did not see Resident #1's physician's verbal order signed 02/15/23. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 04/04/23 at 3:45pm revealed if Resident #1's Novolog was not reduced by 12 units when her FSBS was under 90, the extra insulin would cause her blood sugar to drop even lower. Interview with the Administrator on 04/04/23 at 4:15pm revealed: -She made FSBS logs on her computer and printed them out since there was not enough room on the MAR to write in Resident #1's FSBS and how much insulin was administered. -When she created the FSBS log she typed in Resident #1's current insulin order. -She expected the SIC to edit the insulin order on Resident #1's FSBS logs as soon as the facility	C 330		

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C 330	Continued From page 9 received an updated order. -Sometimes the SIC told her when Resident #1's insulin order changed but she did not always remember to update the typed order on the logs. -She audited the FSBS logs monthly to ensure the correct amount of insulin was being administered. -She was not aware Resident #1's insulin had not been reduced correctly for FSBS less than 90 in February 2023 and March 2023.	C 330		