STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011262	A. BUILDING: _____ B. WING _____	R-C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHUNN'S COVE ASSISTED LIVING	67 MOUNTAIN BROOK ROAD ASHEVILLE, NC 28805

(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 a follow-up survey on 04/11/23-04/12/23.	{D 000}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to serve therapeutic diets as ordered for 3 of 3 residents related to a pureed diet (Resident #2), and a mechanical soft diet (Residents #3 and #4). The findings are: 1. Review of Resident #2's current FL2 dated 03/20/23 revealed diagnoses included right-sided hemiplegia following stroke and history of traumatic brain injury. Review of Resident #2 physician's diet order dated 03/20/23 revealed a pureed diet. Review of the diet order sheet from the kitchen staff on 04/11/23 revealed Resident #2 was on a pureed diet.	{D 310}		

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{D 310}	Continued From page 1 Observation of Resident #2's lunch meal in the secured dining room on 04/11/23 at 12:15pm revealed: -Staff placed the meal tray on the table in front of Resident #2. -Resident #2 received pureed chicken, pureed carrots, rice pilaf (rice with small vegetables) and chocolate pudding. -The surveyor requested the medication aide (MA) observe the consistency of the food on Resident #2's plate. Review of the facility's menus revealed: -There was documentation the lunch meal on 04/11/23 consisted of mango chicken, fried rice, mixed vegetables a dinner roll and cream pie. -There was documentation the lunch menu to be served for a pureed diet consisted of pureed chicken with a sauce, pureed fried rice with a sauce, pureed mixed vegetables and a piece of cream pie. Interview with a MA on 04/11/23 at 12:16pm revealed: -Resident #2 was on a pureed diet. -She observed Resident #2's lunch meal and stated Resident #2's food was pureed consistency. Interview with the transportation aide on 04/11/23 at 12:17pm revealed: -She observed the lunch meal Resident #2 was served and realized it was not pureed. -His rice pilaf was regular rice with small bits of vegetables. -She removed his plate before Resident #2 ate any of the rice and took it back to the kitchen. Interview with a laundry aide on 04/11/23 at	{D 310}		

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{D 310}	Continued From page 2 12:21pm revealed: -She had never helped in the dining room before. -She gave Resident #2 his lunch meal tray. -She did not know what kind of diet Resident #2 should be served. -She had no training related to serving meals to residents on therapeutic diets. Interview with the Dietary Manager (DM) on 04/11/23 at 12:50pm revealed: -Resident #2 was on a pureed diet. -Resident #2 received the wrong diet consistency. -He had cooked the rice pilaf for about an hour. -He assumed it was soft enough, so he did not puree the rice pilaf. -He pureed Resident #2's food for the lunch meal on 04/11/23. Telephone interview with the Primary Care Provider (PCP) on 04/12/23 at 8:56am revealed: -Resident #2 had a stroke and had dysphagia (difficulty swallowing). -Resident #2 was on a pureed diet and was a high risk for aspiration. -When Resident #2 ate, he tended to overload his mouth with food. -Rice was a food that could easily cause choking with someone on a pureed diet. -Concerns for Resident #2 not receiving a pureed diet included choking, hypoxia (decreased oxygen level) and aspiration (liquids or foods that enter the airway) pneumonia. Attempted interview with Resident #2 on 04/11/23 at 12:40pm was unsuccessful. Refer to interview with the Regional Manager on 04/11/23 at 12:58pm. Refer to interview with the Corporate Chef on	{D 310}		

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{D 310}	Continued From page 3 04/11/23 at 1:37pm. Refer to interview with the Administrator on 04/12/23 at 11:29am. 2. Review of Resident #4's current FL2 dated 01/16/23 revealed diagnoses included dysphagia (difficulty swallowing), gastric reflux, dementia and diabetes. Review of Resident #4 physician's diet order dated 03/27/23 revealed a mechanical soft diet (specialized textured foods for people with swallowing problems). Review of the diet order sheet from the kitchen staff on 04/11/23 revealed Resident #4 was on a mechanical soft diet. Observation of Resident #4's lunch meal in the secured dining room on 04/11/23 at 12:18pm revealed: -Staff placed the meal tray on the table in front of Resident #4. -Resident #4 received chopped chicken, pureed carrots, a slice of white bread, rice pilaf and chocolate pudding. Review of the facility's menus revealed: -There was documentation the lunch meal on 04/11/23 consisted of mango chicken, fried rice, mixed vegetables a dinner roll and cream pie. -There was documentation the lunch menu to be served for a mechanical soft diet consisted of ground chicken with a sauce, fried rice with a sauce, mixed vegetables, a dinner roll and a piece of cream pie. Interview with a laundry aide on 04/11/23 at 12:21pm revealed:	{D 310}		

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{D 310}	Continued From page 4 -She had never helped in the dining room before. -She gave Resident #4 her lunch meal tray. -She did not know what kind of diet Resident #4 should be served. -She had no training related to serving meals to residents on therapeutic diets. Observation during the lunch meal on 04/11/23 at 12:23pm revealed: -Staff did not acknowledge Resident #4 was served a chopped diet instead of a mechanical soft diet. -Resident #4 did not eat the chopped chicken or slice of white bread on her meal tray. -Resident #4 had no difficulties feeding herself. -Resident #4 ate 75% of her chocolate pudding, rice pilaf and pureed carrots. Interview with a medication aide (MA) on 04/11/23 at 12:16pm and 1:27pm revealed: -Resident #4 was on a mechanical soft diet. -Mechanical soft food meant that everything on the plate was chopped. -She did not deliver Resident #4's lunch tray. -She did not actually see Resident #4's lunch meal. -She was only in the dining room at lunch to be present if someone choked. Interview with the Dietary Manager (DM) on 04/11/23 at 12:50pm revealed: -Resident #4 was on a mechanical soft diet. -It was his mistake Resident #4 received the wrong diet consistency. Telephone interview with the PCP on 04/12/23 at 8:56am revealed: -Resident #4 was on a mechanical soft diet. -He could not remember why Resident #4 was on a mechanical soft diet.	{D 310}		

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{D 310}	Continued From page 5 -Resident #4's diagnoses from the FL2 dated 01/16/23 were read to the PCP he indicated her mechanical soft diet was due to her dysphagia. -Concerns for Resident #4 not receiving a mechanical soft diet included choking, hypoxia (decreased oxygen level) and aspiration pneumonia. Attempted interview with Resident #4 on 04/11/23 at 12:43pm was unsuccessful. Refer to interview with the Regional Manager on 04/11/23 at 12:58pm. Refer to interview with the Corporate Chef on 04/11/23 at 1:37pm. Refer to interview with the Administrator on 04/12/23 at 11:29am. 3. Review of Resident #3's current FL2 dated 02/06/23 revealed: -Diagnoses included hyperglycemia and acute kidney injury. -An order for a diabetic diet. Review of Resident #3's physician order dated 03/30/23 revealed an order for a mechanical soft diet with ground meat (specialized textured foods for people with swallowing problems). Review of the resident diet orders list posted in the kitchen revealed Resident #3's diet was documented as mechanical soft. Interview with Resident #3 on 04/11/23 at 9:15am and 04/12/23 at 11:30am revealed: -She was supposed to be on a diabetic diet but did not think she received that. -She was tried on a ground meat diet when she	{D 310}		

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{D 310}	Continued From page 6	{D 310}		

was in the hospital a few weeks ago but she did not think it was continued when she was discharged.
-She received chopped meat after she was discharged from the hospital.

Observation of the lunch meal service on 04/11/23 at 12:25pm revealed:
-Resident #3 was served diced chicken with a sauce, rice pilaf with small pieces of vegetables, ground green beans, a slice of bread and chocolate pudding.
-The Regional Manager removed the plate served to Resident #3, at the surveyor's request, and replaced it with a plate that contained ground meat mixed with ground rice with a sauce on it.

Review of the facility's menus revealed:
-There was documentation the lunch meal on 04/11/23 consisted of mango chicken, fried rice, mixed vegetables a dinner roll and cream pie.
-There was documentation the lunch menu to be served for a mechanical soft diet consisted of ground chicken with a sauce, fried rice with a sauce, mixed vegetables, a dinner roll and a piece of cream pie.

Interview with the Dietary manager (DM) on 04/11/23 at 12:32pm revealed:
-Resident #3 was on a mechanical soft diet with chopped meat.
-When a resident was ordered a mechanical soft diet, the meat was specified as either chopped or ground and he was told Resident #3 was supposed to receive chopped meat.
-The Resident Care Coordinator (RCC) was responsible for informing him of residents' diet orders.
-The RCC would tell him when a diet changed but she would also bring an updated diet list to post in

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{D 310}	Continued From page 7	{D 310}		

the kitchen.
-He thought the mechanical soft menu documented the vegetable should be ground.

Interview with the RCC on 04/11/23 at 1:00pm revealed:
-She was responsible for informing the DM of residents' diet orders.
-Ground meat should always be served for a mechanical soft diet.
-She went to the kitchen and told the DM when Resident #3's diet changed to mechanical soft and she also posted a new diet order list.

Interview with the Administrator on 04/11/23 at 12:53pm revealed:
-The RCC was responsible for taking new diet orders to the kitchen and informing the DM of changes.
-Ground meat should always be served for a mechanical soft diet.

Interview with the Corporate Chef on 04/11/23 at 1:38pm revealed:
-He started coming to the facility a few weeks ago.
-The corporate menus documented ground meat should be served on a mechanical soft diet.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 04-12-23 at 8:56am revealed:
-Resident #3 was recently admitted to the hospital to rule out a stoke, at which time she was treated by speech therapy.
-Speech therapy conducted testing and it was documented Resident #3 needed a mechanical soft diet with ground meat.
-Resident #3 ate quickly which compounded her risk for choking due to dysphagia so he changed

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{D 310}	Continued From page 8 her to a mechanical soft diet with ground meat for her safety as the speech therapist recommended upon her hospital discharge. -If she did not receive a mechanical soft diet with ground meat, she was at risk for choking which could result in hypoxia (decreased oxygen level) or aspiration pneumonia. Refer to interview with the Regional Manager on 04/11/23 at 12:58pm. Refer to interview with the Corporate Chef on 04/11/23 at 1:37pm. Refer to interview with the Administrator on 04/12/23 at 11:29am. _____ Interview with the Regional Manager on 04/11/23 at 12:58pm revealed: -It was the responsibility of the DM to ensure the therapeutic diets were served to the residents per the physician's order. -He was not aware Resident #2, #3 and #4 were not receiving the prescribed therapeutic diets. Interview with the Corporate Chef on 04/11/23 at 1:37pm revealed: -He had observed the DM prepare pureed and ground foods correctly and had no concerns about the consistency. -He had not observed the lunch meal tray delivered to Resident #2, #3 and #4 on 04/11/23. -This was a mistake for the DM not to prepare the meal according to the therapeutic diet ordered by the physician. Interview with the Administrator on 04/12/23 at 11:29am revealed: -The DM knew which residents were on	{D 310}		

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{D 310}	Continued From page 9 therapeutic diets. -There was a therapeutic diet list posted in the kitchen that the Resident Care Coordinator kept updated. -She was not aware the residents were not being served the diet ordered by the PCP. _____ The facility failed to serve therapeutic diets as ordered to Resident #2 related to a pureed diet, and to Resident #3 and Resident #4 related to a mechanical soft diet., which increased the risk of choking, hypoxia (decreased oxygen level) and aspiration pneumonia. This failure was detrimental to the residents health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/12/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 27, 2023.	{D 310}		
{D 319}	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Based on interviews and record review, the	{D 319}		

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{D 319}	Continued From page 10 facility failed to ensure each resident in the facility had the opportunity to participate in at least one outing every other month. The findings are: Review of the March 2023 activity calendar presented by the Administrator revealed there were no outings scheduled. Observation of the April 2023 activity calendar posted in the living rooms revealed there were no outings scheduled. Interviews with 6 residents during the facility initial tour on 04/11/23 between 9:10am-9:55am revealed: -Residents had not been taken on any outings since the start of COVID-19 in 2020. -Residents never went anywhere for activities. -One resident had not gone on any outings since her admission a few months ago. -A second resident was bored because no one was ever taken on any outside activities. -A third resident had to "beg" staff to be taken to the store. -A fourth resident had lived at the facility for 2 1/2 years and could not remember being taken on outings by the facility on more than two occasions. Interview with the transportation aide (TA) on 04/11/23 at 9:31am revealed: -She was responsible for transporting residents to medical appointments and for activities. -The residents on the secured unit were not taken off the property for activities. -There was no resident check off list to ensure every resident was given the opportunity to go on an outing every other month.	{D 319}		

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{D 319}	Continued From page 11 Interview with a medication aide (MA) on 04/12/23 at 9:39am revealed: -She was not aware of what was listed on the activity calendar. -She was not sure who was responsible for providing activities for the residents when the Activity Director was not working. Interview with the Regional Manager on 04/11/23 at 9:48am revealed he had not reviewed the April 2023 activity calendars posted in the secured unit or the Assisted Living (AL) unit. Interview with the Administrator on 04/12/23 at 10:36am and 11:29am revealed: -There should be an activity available for residents outside the facility at least every other month. -The residents on the secured unit had not been going on any community outings. -There were no community outings planned for March and April 2023 on the activity calendars. Attempted telephone interview with the AD on 04/12/23 at 10:15am was unsuccessful.	{D 319}		
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.	D 358		

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D 358	Continued From page 12	D 358		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 2 sampled residents with insulin orders (Resident #4) including a fast-acting insulin ordered to treat high blood sugars.

The findings are:

Review of Resident #4's current FL2 dated 02/27/23 revealed:
-Diagnoses included major neurocognitive disorder and dementia.
-There was an order for Humalog Kwikpen (a fast-acting insulin used to treat high blood sugar) 100u/ml check fingerstick blood sugar (FSBS) before meals and give sliding scale insulin as follows: less than 70 treat low blood sugar; less than 180=0 units; 181-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; greater than 400=6 units.

Review of Resident #4's March 2023 electronic Medication Administration Record (eMAR) from 03/26/23 to 03/31/23 revealed:
-There was an entry for Humalog Kwikpen 100u/ml check blood sugar before meals and give sliding scale insulin as follows: less than 70 treat low blood sugar; less than 181=0 units; 181-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; greater than 400=6 units scheduled at 8:00am, 12:00pm, and 5:00pm.
-Humalog Kwikpen was documented as administered incorrectly for 9 occurrences out of

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D 358	Continued From page 13 18 opportunities. -The range of premeal FSBS's from 03/26/23 to 03/31/23 was 140-493. -On 3/29/23 at 8:00am, FSBS 235, 1 unit was documented as administered, 2 units were required. -On 03/26/23 at 12:00pm, FSBS 285, 2 units were documented as administered, 3 units were required. -On 03/26/23 at 5:00pm, FSBS 345, 3 units were documented as administered, 4 units were required. -On 03/27/23 at 12:00pm, FSBS 305, 3 units were documented as administered, 4 units were required. -On 03/27/23 at 5:00pm, FSBS 375, 4 units were documented as administered, 5 units were required. -On 03/28/23 at 12:00pm, FSBS 334, 3 units were documented as administered, 4 units were required. -On 03/28/23 at 5:00pm, FSBS 448, 5 units were documented as administered, 6 units were required. -On 03/31/23 at 12:00pm, FSBS 319, 3 units were documented as administered, 4 units were required. -On 03/31/23 at 5:00pm, FSBS 413, 5 units were documented as administered, 6 units were required. Review of Resident #4's April 2023 eMAR from 04/01/23 to 04/11/23 revealed: -There was an entry for Humalog Kwikpen 100u/ml check blood sugar before meals and give sliding scale insulin as follows: less than 70 treat low blood sugar; less than 181=0 units; 181-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; greater than 400=6 units scheduled at 8:00am, 12:00pm,	D 358		

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D 358	Continued From page 14 and 5:00pm. -Humalog Kwikpen was documented as administered incorrectly for 9 occurrences out of 32 opportunities. -The range of premeal FSBS's from 04/01/23 to 04/11/23 was 108-533. -On 04/01/23 at 8:00am, FSBS was 252, 2 units were documented as administered, 3 units were required. -On 04/02/23 at 5:00pm, FSBS was 512, 9 units were documented as administered, 6 units were required. -On 04/03/23 at 12:00pm, FSBS was 397, 4 units were documented as administered, 5 units were required. -On 04/04/23 at 8:00am, FSBS was 108, 5 units were documented as administered, 0 units were required. -On 04/04/23 at 12:00pm, FSBS 315, 3 units were documented as administered, 4 units were required. -On 04/04/23 at 5:00pm, FSBS 351, 4 units were documented as administered, 5 units were required. -On 04/07/23 at 12:00pm, FSBS 233, 4 units were documented as administered, 2 units were required. -On 04/09/23 at 8:00am, FSBS 354, 2 units were documented as administered, 5 units were required. -On 04/11/23 at 8:00am, FSBS 180, 4 units were documented as administered, 0 units were required. Observation of Resident #4's medications on hand on 04/12/23 at 10:52am revealed Humalog Kwikpen was available for administration. Interview with a medication aide (MA) on 04/11/23 at 12:35pm revealed:	D 358		

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-He received training on administering insulin.
-He received training on how to read sliding scales to determine the proper amount of insulin to administer.
-The sliding scale was visible in the eMAR for the staff's guidance for preparation of Resident #4's insulin.
-He could have documented the wrong amount of sliding scale insulin in the eMAR system.
-He knew he administered the correct amount of sliding scale insulin to Resident #4.

Interview with the Resident Care Coordinator (RCC) on 04/11/23 at 12:50pm revealed:
-The eMAR system was confusing as to where to document the sliding scale insulin in the eMAR system when there was also an order for a premeal scheduled dose of insulin.
-She may have documented the wrong amount of sliding scale insulin in the eMAR system.
-She knew she administered the correct amount of sliding scale insulin.

Interview with the RCC on 04/12/23 at 11:45am revealed:
-She performed weekly audits of all resident eMARs during medication cart audits.
-She did review the documented insulin entries and they "looked right."
-The MAs were trained on how to read sliding insulin scales to determine correct dosages.
-She felt staff administered the sliding scale insulin correctly.
-She felt staff may have documented the units of insulin administered incorrectly in the eMAR, rather than giving incorrect dosages.

Interview with the Administrator on 04/12/23 at 11:35am revealed:
-MAs received training on how to properly

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D 358	Continued From page 16	D 358		

administer sliding scale insulin.
-She and the RCC stressed the importance to staff of being very careful with insulin dosages.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 04/12/23 at 11:50am revealed:
-Inaccurate dosing of fast acting insulin could have short term and long term effects for Resident #4.
-Resident #4 would experience high blood sugars if staff were not giving the prescribed amount of insulin.
-Resident #4 could experience low blood sugars if staff gave too much sliding scale insulin.
-Long term effects of poor blood sugar control included damage to every organ in the body.
-Kidney damage and damage to the eyes were usually the first areas to show signs of the long term effects of poor blood sugar control.
-The insulin needed to be administered as it was ordered to control Resident #4's blood sugar.

Review of the facility's medication administration policy revealed medications will be administered in accordance with the prescribing practitioner's orders.

_____

The facility failed to administer sliding scale insulin to Resident #4 as it was prescribed increasing the resident's risk of developing damage initially to the kidneys and eyes, and eventual damage to every organ in the body. This failure was detrimental to Resident #4's health, safety, and welfare and constitutes a Type B Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/12/23 for this violation.

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D 358	Continued From page 17 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 27, 2023.	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: (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 interviews and record reviews, the facility failed to ensure the electronic Medication Administration Records (eMARs) were accurate for 2 of 2 sampled residents with insulin orders (#3 and #4) related to documentation of premeal	{D 367}		

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{D 367}	Continued From page 18 sliding scale (#3 and #4) and premeal scheduled insulin (#3 and #4). The findings are: 1. Review of Resident #3's current FL2 dated 02/06/23 revealed diagnoses included acute kidney injury and hyperglycemia. Review of Resident #3's physician's order sheet dated 03/06/23 revealed: -There was an order for Humalog Kwikpen (used to treat high blood sugar) 100u/ml check fingerstick blood sugar (FSBS) before meals and at bedtime and give sliding scale insulin as follows: less than 70 treat low blood sugar; less than 180=0 units; 181-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; greater than 400=6 units. -There was an order for Humalog Kwikpen 100u/ml 5 units three times a day with meals. Review of Resident #3's March 2023 electronic Medication Administration Record (eMAR) from 03/26/23 to 03/31/23 revealed: -There was an entry for Humalog Kwikpen 100u/ml check fingerstick blood sugar (FSBS) before meals and at bedtime and give sliding scale insulin as follows: less than 70 treat low blood sugar; less than 180=0 units; 181-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; greater than 400=6 units scheduled at 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was an entry for Humalog Kwikpen 100u/ml 5 units three times a day with meals scheduled at 8:00am, 12:00pm, and 5:00pm. -On 03/29/23 at 12:00pm, FSBS 253, 5 units documented as administered for sliding scale (3 units required), 3 units documented for scheduled	{D 367}		

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{D 367}	Continued From page 19 (5 units required). -On 03/30/23 at 12:00pm, FSBS 400, 5 units documented as administered for sliding scale (6 units required), 6 units documented for scheduled (5 units required). Review of Resident #3's April 2023 eMAR from 04/01/23 to 04/11/23 revealed: -There was an entry for Humalog Kwikpen 100u/ml check FSBS before meals and at bedtime and give sliding scale insulin as follows: less than 70 treat low blood sugar; less than 180=0 units; 181-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; greater than 400=6 units scheduled at 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was an entry for Humalog Kwikpen 100u/ml 5 units three times a day with meals scheduled at 8:00am, 12:00pm, and 5:00pm. -On 04/02/23 at 12:00pm, FSBS 262, 5 units documented as administered for sliding scale (3 units required), 3 units documented for scheduled (5 units required). -On 04/04/23 at 8:00am, FSBS 189, 5 units documented as administered for sliding scale (0 units required), 0 units documented for scheduled (5 units required). -On 04/04/23 at 12:00pm, FSBS 290, 5 units documented as administered for sliding scale (3 units required), 3 units documented for scheduled (5 units required). -On 04/05/23 at 8:00am, FSBS 171, 5 units documented as administered for sliding scale (0 units required), 0 units documented for scheduled (5 units required). -On 04/06/23 at 5:00pm, FSBS 310, 5 units documented as administered for sliding scale (4 units required), 4 units documented for scheduled (5 units required). -On 04/07/23 at 12:00pm, FSBS 208, 5 units	{D 367}		

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{D 367}	Continued From page 20	{D 367}		

documented as administered for sliding scale (4 units required), 4 units documented for scheduled (5 units required).
-On 04/08/23 at 12:00pm, FSBS 285, 5 units documented as administered for sliding scale (3 units required), 3 units documented for scheduled (5 units required).
-On 04/09/23 at 12:00pm, FSBS 212, 5 units documented as administered for sliding scale (2 units required), 2 units documented for scheduled (5 units required).
-On 04/10/23 at 8:00am, FSBS 228, 5 units documented as administered for sliding scale (2 units required), 2 units documented for scheduled (5 units required).
-On 04/10/23 at 12:00pm, FSBS 434, 5 units documented as administered for sliding scale (6 units required), 6 units documented for scheduled (5 units required).
-On 04/11/23 at 8:00am, FSBS 422, 5 units documented as administered for sliding scale (6 units required), 6 units documented for scheduled (5 units required).

Interview with the Resident Care Coordinator (RCC) on 04/11/23 at 12:50pm revealed:
-She administered Resident #3's Humalog Kwikpen sliding scale and scheduled insulin at 8:00am that morning.
-She administered 11 units total of Humalog Kwikpen to Resident #3 which included 5 scheduled and 6 sliding scale units.
-She had mistakenly "flipped" the documentation of the number of units given for the sliding scale and scheduled on the eMAR.
-She may have documented the wrong amount of sliding scale and scheduled premeal insulin in the eMAR system.

Refer to the interview with the Resident Care

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{D 367}	Continued From page 21 Coordinator (RCC) on 04/11/23 at 12:55pm. Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 04/11/23 at 3:00pm. Refer to the interview with the Administrator on 04/12/23 at 11:35am. Refer to the interview with the RCC on 04/12/23 at 11:45am. 2. Review of Resident #4's current FL2 dated 02/27/23 revealed: -Diagnoses included major neurocognitive disorder and dementia. -There was an order for Humalog Kwikpen (used to treat high blood sugar) 100u/ml check fingerstick blood sugar (FSBS) before meals and give sliding scale insulin as follows: less than 70 treat low blood sugar; less than 180=0 units; 181-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; greater than 400=6 units. -There was an order for Humalog Kwikpen 100u/ml 4 units three times a day with meals. Review of Resident #4's March 2023 electronic Medication Administration Record (eMAR) from 03/26/23 to 03/31/23 revealed: -There was an entry for Humalog Kwikpen 100u/ml check blood sugar before meals and give sliding scale insulin as follows: less than 70 treat low blood sugar; less than 181=0 units; 181-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; greater than 400=6 units scheduled at 8:00am, 12:00pm, and 5:00pm. -There was an entry for Humalog Kwikpen 100u/ml 4 units three times a day with meals	{D 367}		

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{D 367}	Continued From page 22 scheduled at 8:00am, 12:00pm, and 5:00pm. -There were no documentation errors. Review of Resident #4's April 2023 eMAR from 04/01/23 to 04/11/23 revealed: -There was an entry for Humalog Kwikpen 100u/ml check blood sugar before meals and give sliding scale insulin as follows: less than 70 treat low blood sugar; less than 181=0 units; 181-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; greater than 400=6 units scheduled at 8:00am, 12:00pm, and 5:00pm. -There was an entry for Humalog Kwikpen 100u/ml 4 units three times a day with meals scheduled at 8:00am, 12:00pm, and 5:00pm. -On 04/07/23 at 12:00pm, FSBS 233, 4 units documented as administered for sliding scale (2 units required), 2 units documented for scheduled (4 units required). Refer to the interview with the Resident Care Coordinator (RCC) on 04/11/23 at 12:55pm. Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 04/11/23 at 3:00pm. Refer to the interview with the Administrator on 04/12/23 at 11:35am. Refer to the interview with the RCC on 04/12/23 at 11:45am. _____ Interview with the Resident Care Coordinator (RCC) on 04/11/23 at 12:55pm revealed: -The data input areas of the eMAR for Humalog sliding scale and scheduled premeal Humalog appeared on top of each other in the eMAR system.	{D 367}		

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{D 367}	Continued From page 23 -There was no way to distinguish which input area was for the sliding scale units administered or for the scheduled units administered. -The eMAR system was confusing as to where to document the sliding scale insulin when there was also an order for a premeal scheduled dose of insulin. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/11/23 at 3:00pm revealed: -The pharmacy was responsible for entering medication and treatment orders into the residents eMARs. -In the eMAR, premeal sliding scale insulin and premeal scheduled insulin orders were grouped together. -If the sliding scale insulin option was not applied to those eMAR entries, one could not distinguish in the eMAR where to enter the number of units of sliding scale administered and the number of units of scheduled insulin administered. -If the sliding scale insulin option was applied, a blue box appeared to the right of the data entry points which provided directions to the user for the sliding scale and premeal scheduled insulin. -The pharmacy had failed to activate the sliding scale option on the insulin orders when they had entered the order. -The staff person at the facility who approved orders in the eMAR was able to activate the sliding scale option on the insulin orders. Interview with the Administrator on 04/12/23 at 11:35am revealed: -The RCC was responsible for ensuring the eMAR documentation was accurate. -She recently administered medications in the facility. -She administered sliding scale and premeal	{D 367}		

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{D 367}	Continued From page 24 scheduled insulin to two residents. -It was hard for her to discern from the eMAR input areas where to document the units of sliding scale administered and the units of premeal scheduled insulin administered. -She looked at a printed eMAR on 04/11/23 and discovered, she had documented the insulin she administered incorrectly on the eMAR. Interview with the RCC on 04/12/23 at 11:45am revealed: -She reviewed eMAR documentation weekly for all residents. -She did review the documented insulin entries and they "looked right." -She looked at the eMARs electronically, but did not print them out during her audits. -She had been unable to see the documentation discrepancies just looking at the electronic version of the eMARs.	{D 367}		