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
	HAL-013046	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS CABARRUS	4968 MILESTONE AVE KANNAPOLIS, NC 28081

(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 survey on 03/29/23 and 03/30/23.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies; the Plan of Correction is prepared solely as a matter of compliance with State Law.	
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure signed physician's orders were implemented for 1 of 5 residents related to initiating a scheduled medication used to control pain and discontinuing an as needed medication used to control pain (Resident #3). The findings are: Review of Resident #3's current FL2 dated 02/09/23 revealed: -Diagnoses included dementia and hypertension. -The recommended level of care was the Special Care Unit (SCU). -There was a signed order for acetaminophen 500mg every six hours as needed. Review of Resident #3's Primary Care Provider's (PCP) signed orders dated 01/10/23 revealed an order for acetaminophen 500mg every six hours as needed. Review of Resident #3's PCP's signed visit note	D 276	10A NCAC 13F .0902 Healthcare Training was conducted on 4/25/23 to ensure order implementation procedures for all orders. The "bucket system" was reimplemented to ensure all orders are received, reviewed for accuracy, faxed to pharmacy and received in facility prior to orders being placed/removed from MAR. Care Coordinator (CC) and Memory Care (MC) manager to monitor daily to ensure all orders are completed/discontinued and approved. Monthly audits to be completed by Executive Director (ED) and the Regional Director of Operations (RDO) to ensure facility is in compliance.	4/25/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mariah Henry | TITLE: Executive Director | (X6) DATE: 4/28/2023

Reviewed and Acknowledged by Sharon Dunton on 05/03/2023

Sharon Dunton RN

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D 276	Continued From page 1 dated 01/31/23 revealed: -There was an order to discontinue acetaminophen 500mg every six hours as needed. -There was an order for acetaminophen 500mg, two tablets, three times per day. Review of Resident #3's January 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry dated 12/20/22 for acetaminophen 500mg every six hours as needed. -There was no documentation acetaminophen 500mg as needed was administered. -There was no entry for acetaminophen 500mg, two tablets, three times per day. Review of Resident #3's February 2023 eMAR revealed: -There was an entry dated 12/20/22 for acetaminophen 500mg every six hours as needed. -Acetaminophen 500mg as needed was documented as administered on 02/03/23 at 1:20pm. -There was no entry for acetaminophen 500mg, two tablets, three times per day. Interview with a medication aide (MA) on 03/30/23 at 11:57am revealed: -She gave new medication orders she received to the Special Care Unit Coordinator (SCC) or the Resident Care Coordinator (RCC). -MAs were not able to add medications to the eMAR. Interview with the SCC on 03/30/23 at 1:31pm revealed: -She, the RCC, and the Administrator were	D 276		

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D 276	Continued From page 2 responsible for sending medication orders to the pharmacy and the pharmacy entered the medication on the eMAR. -She, the RCC, and the Administrator were able to discontinue medication on the eMAR if they had an order from the PCP. -She read PCP notes to look for new orders and did not know why she did not send Resident #3's PCP note dated 01/31/23 with the orders to discontinue acetaminophen 500mg every six hours as needed and start acetaminophen 500mg, two tablets, three times per day to the pharmacy. Interview with the RCC on 03/30/23 at 12:52pm revealed: -She, the SCC, and the Administrator sent medication orders to the pharmacy and the pharmacy entered the medication on the eMAR. -She and the SCC were able to discontinue medications on the eMAR with an order but she also sent the discontinue order to the pharmacy. -She read the PCP's notes to look for any new orders. -She did not know Resident #3's PCP ordered scheduled acetaminophen and discontinued the as needed acetaminophen on 01/31/23. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 03/30/23 at 3:51pm revealed: -The pharmacy had not received an order for Resident #3 for acetaminophen 500mg, two tablets, three times per day. -There was an active order for acetaminophen 500mg every six hours as needed dated 02/09/23. -The pharmacy added medications to the facility's eMARs.	D 276		

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D 276	Continued From page 3 Telephone interview with Resident #3's PCP on 03/30/23 at 4:41pm revealed: -She wrote an order for scheduled acetaminophen on 01/31/23 due to Resident #3 complaining of pain after a fall on 01/29/23. -Resident #3 had a history of dementia and she did not think Resident #3 could approach an MA to ask for medication to treat the pain. -The as needed acetaminophen order was discontinued on 01/31/23 because if Resident #3 received the scheduled and as needed acetaminophen on the same day it would put her over the daily limit for acetaminophen. Interview with the Administrator on 03/30/23 at 4:53pm revealed: -The SCC and RCC were responsible for sending medication orders to the pharmacy so the medication could be dispensed and the pharmacy could enter the medication on the eMAR. -The SCC and RCC were responsible for reading the PCP's visit notes to identify new orders. -She tried to audit medication orders against the eMAR quarterly but could not remember the date of the last audit.	D 276		
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 4 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 2 of 5 sampled residents (#2 and #4) related to a medication to lower blood sugar (#2 and #4). The findings are: 1. Review of Resident #4's current FL2 dated 02/01/23 revealed diagnoses included diabetes mellitus, hypertension, and coronary artery disease. Review of Resident #4's Primary Care Provider's (PCP) orders dated 07/25/22 revealed: -There was an order for basaglar insulin 45 units at bedtime. -Resident #4's FSBS was to be checked twice daily before breakfast and dinner. Review of Resident #4's PCP order dated 08/10/22 revealed an order for basaglar insulin 10 units in the morning. Review of Resident #4's PCP order dated 11/03/22 revealed the basaglar insulin was to be held if the resident's FSBS was less than 100. Review of Resident #4's PCP order dated 02/02/23 revealed the basaglar insulin morning dose was to be increased to 20 units. Review of Resident #4's January 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for basaglar insulin 10 units each morning. -There was an entry to check the resident's FSBS before breakfast and dinner and hold for FSBS	D 358	10A NCAC 13F .1004(a) Medication Medication Administration training held on 4/25/23 by the Area Clinical Director (ACD) for Care Coordinators and Medication Techs on proper recording/documentation of orders, understanding Diabetes and documentation of FSBS, sliding scale insulin and perimeters, medication errors/notification to providers. Area Clinical Director and Care Coordinators will educate and train new employees upon hire and annually on how to record FSBS, proper techniques to follow when not administering insulin due to low results and provider notified of such.	4/25/23

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D 358	Continued From page 5 less than 100. -There were three instances the resident's FSBS was less than 100 and basaglar insulin was administered. -On 01/16/23 at 7:30am the resident's FSBS was 84 and basaglar insulin 10 units was documented as administered. -On 01/17/23 at 7:30am the resident's FSBS was 88 and basaglar insulin 10 units was documented as administered. -On 01/30/23 at 7:30am the resident's FSBS was 74 and basaglar insulin 10 units was documented as administered. Review of Resident #4's March 2023 eMAR revealed: -There was an entry for basaglar insulin 20 units each morning. -There was an entry to check the resident's FSBS before breakfast and dinner and hold for FSBS less than 100. -There were six instances the resident's FSBS was less than 100 and basaglar insulin was administered. -On 03/02/23 at 7:30am the resident's FSBS was 77 and basaglar insulin 20 units was documented as administered. -On 03/09/23 at 7:30am the resident's FSBS was 77 and basaglar insulin 20 units was documented as administered. -On 03/16/23 at 7:30am the resident's FSBS was 58 and basaglar insulin 20 units was documented as administered. -On 03/17/23 at 7:30am the resident's FSBS was 84 and basaglar insulin 20 units was documented as administered. -On 03/25/23 at 7:30am the resident's FSBS was 83 and basaglar insulin 20 units was documented as administered. -On 03/26/23 at 7:30am the resident's FSBS was	D 358		

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D 358	Continued From page 6 93 and basaglar insulin 20 units was documented as administered. Interview with a medication aide (MA) on 03/30/23 at 4:28pm revealed: -There was an entry on Resident #4's eMAR indicating her basaglar insulin was to be held if her FSBS was less than 100. -There were times she needed to hold Resident #4's basaglar insulin because her FSBS was less than 100. -When Resident #4's FSBS was less than 100 she documented the basaglar insulin was not administered and made a note in the comment box stating Resident #4's FSBS was less than 100. -She was unsure if residents' eMARs were audited for errors. Attempted telephone interview with Resident #4's PCP on 03/30/23 at 4:50pm was unsuccessful. Interview with the Administrator on 03/30/23 at 4:53pm revealed: -The MAs were responsible to administer and hold medications as ordered by the PCP. -The RCC, SCC, or Administrator were responsible to audit the eMARs quarterly for accuracy but they were behind on the audits. 2. Review of Resident #2's current FL2 dated 02/21/23 revealed diagnoses included diabetes mellitus, hypertension, weakness, obstructive sleep apnea and lumbar spondylosis. Review of Resident #2's current Primary Care Provider's (PCP) orders dated 02/21/23 revealed, check finger stick blood sugar (FSBS) before each meal and inject humalog insulin per sliding scale: FSBS: 151-200 = 1 unit, 201-250 = 2	D 358		

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D 358	Continued From page 7 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, greater than 400 call endocrinology. Review of Resident #2's January 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check FSBS and inject humalog insulin subcutaneously per sliding scale three times a day before meals: FSBS: 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, if above 400 call endocrinology. -Her FSBS on 02/16/23 at 11:30am was 165 and she received no humalog insulin, when 1 unit should have been administered. -Her FSBS on 01/19/23 at 7:30am was 277 and she received 2 units of humalog insulin, when 3 units should have been administered. -Her FSBS on 01/19/23 at 11:30am was 277 and she received 2 units of humalog insulin, when 3 units should have been administered. -Her FSBS on 01/22/23 at 7:30am was 269 and she received 2 units of humalog insulin, when 3 units should have been administered. -Her FSBS on 01/31/23 at 7:30am was 214 and she received 1 unit of humalog insulin, when 2 units should have been administered. Review of Resident #2's February 2023 eMAR revealed: -There was an entry to check FSBS and inject humalog insulin subcutaneously per sliding scale three times a day before meals: FSBS: 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, if above 400 call endocrinology. -Her FSBS on 02/06/23 at 7:30am was 200 and she received 2 units of humalog insulin, when 1 unit should have been administered.	D 358		

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D 358	Continued From page 8 -Her FSBS on 02/18/23 at 7:30am was 205 and she received 1 unit of humalog insulin, when 2 units should have been administered. -Her FSBS on 02/19/23 at 7:30am was 151 and she received no humalog insulin, when 1 unit should have been administered. Review of Resident #2's March 2023 eMAR revealed: -There was an entry to check FSBS and inject humalog insulin subcutaneously per sliding scale three times a day before meals: FSBS: 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, if above 400 call endocrinology. -Her FSBS on 03/05/23 at 7:30am was 173 and she received no humalog insulin, when 1 unit should have been administered. -Her FSBS on 03/11/23 at 7:30am was 127 and she received 1 unit of humalog insulin, when no humalog insulin should have been administered. -Her FSBS on 03/12/23 at 7:30am was 141 and she received 1 unit of humalog insulin, when no humalog insulin should have been administered. -Her FSBS on 03/15/23 at 5:00pm was 150 and she received 1 unit of humalog insulin, when no humalog insulin should have been administered. Observation of the medication aide (MA) on 03/29/23 at 11:50am revealed: -The MA checked Resident #2's FSBS. -Resident #2's FSBS before lunch was 147. -She checked the order for humalog sliding scale insulin and gave no units of humalog insulin. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/30/23 at 3:56pm revealed: -There was an order dated 12/20/22 for humalog insulin, check FSBS before each meal and inject	D 358		

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D 358	Continued From page 9 per sliding scale: FSBS: 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, greater than 400 call endocrinology. -Five humalog KwikPens, 300 units each, were filled on 01/11/23 and 03/30/23 -The outcome of giving too much humalog insulin could make the blood sugar to be low, with symptoms of dizziness, sweating and increased heartrate. -The outcome of giving too little humalog insulin could cause the resident to be thirsty or tired. Interview with a MA on 03/29/23 at 11:50am revealed: -The MAs were responsible for checking Resident #2's FSBS before meals. -The eMAR did not populate the sliding scale insulin to be given after the FSBS was documented. -She was not sure if the charts were audited. -She was never made aware if an error was made when sliding scale was given. -She had education on sliding scale insulin about 2 months ago when Resident #2 received the order. Interview with the Regional Director of Operations (RDO) on 3/30/23 at 9:47am revealed: -She was at the facility approximately 2 times a month. -The chart audits had not been completed lately. -The Executive Director (ED) and the Resident Care Manager (RCC) audited the charts. -She had not audited the eMAR this year. Interview with the RCC on 3/20/23 at 12:52 pm revealed: -All medications were put on the eMAR by the pharmacy.	D 358		

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D 358	Continued From page 10 -The RDO audited the eMAR for sliding scale insulin documentation. -The RCC did not do any auditing. -She received her training when she started her position but did not get all the way through the training because of staffing issues. Interview with the ED on 03/30/23 at 4:51pm revealed: -She was not aware of any sliding scale insulin errors on the eMAR. -Chart audits and eMAR audits had not been done lately. -The RCC and the ED were responsible for eMAR audits. -She expected eMAR audits to be done quarterly but the facility was behind on them. -When the FSBS was documented on the eMAR, the software did not automatically populate the amount of sliding scale insulin to be given. -All MAs were educated on sliding scale insulin about 2 months ago when Resident #2 received the sliding scale insulin order.	D 358		