

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL036035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2023
NAME OF PROVIDER OR SUPPLIER WALDEN POND CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p style="text-align: center;">It is the Policy of CCJ Adult Care LLC dba Walden Pond Care Home</p> <p style="text-align: center;">To be in Compliance with. Rule 10A NCAC 13G.1002(a) Rule 10A NCAC 13G.1004(a)</p> <p>4/4/23 Immediately called Facility MD for Clarification/ Informed him that Ordered had been transcribed to F12 incorrectly but Resident had received the correct amount of Insulin. Informed him that Resident had not received the correct amount for her premeal reading.</p>	May 31, 2023
C 315	<p>10A NCAC 13G .1002(a) Medication Orders</p> <p>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.</p> <p>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.</p> <p>The findings are:</p> <p>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.</p>	C 315		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Bernice R Hosch

Bernice R. Hosch

Administrator

4-14-23

STATE FORM

5899

8KFF11

If continuation sheet 1 of 10

Reviewed and acknowledged 05/08/23
Brianna Jameson

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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	Measures CCJ Adult Care LLC IV dba Walden Pond Care Home will be putting in place. Measures CCJ Adult Care LLC IV dba Walden Pond Care Home will put the following measures in place to prevent the problem from occurring again 1 New FSBS Sheet designed 2 Administrator & SIC will review FSBS Sheet weekly on Fridays 3 SIC/MT will inform Admin of any FSBS reading under 100 4 SIC/Administrator will check FL2 before sending to MD to ensure all orders are correct 5 Facility will get NEW MAR for New Orders 6 Facility will document on top of New FSBS Changed Order	May 31, 2023

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C 315	Continued From page 2 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.	C 315	Who will monitor the situation to ensure it will not occur again How often the monitoring will take place Administrator & SIC will review FSBS Sheet weekly on Fridays	May 31, 2023

Division of Health Service Regulation

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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		

Division of Health Service Regulation

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C 330	<p>Continued From page 5</p> <p>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.</p> <p>-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".</p> <p>Review of Resident #1's March 2023 11:30am FSBS log revealed:</p> <p>-Resident #1's FSBS at 11:30am and the amount of insulin administered were documented from 03/01/23 through 03/31/23.</p> <p>-A typed entry for Novolog 31 units before lunch reduce by 4 units if FSBS under 90.</p> <p>-There was a handwritten entry dated 03/16/23, reduce by 12 units if FSBS under 90.</p> <p>-There was one occurrence when Resident #1's FSBS was under 90.</p> <p>-On 03/29/23 FSBS was 71 and 20 units of insulin were documented as administered.</p> <p>Refer to interview with Resident #1 on 04/04/23 at 4:05pm.</p> <p>Refer to interview with the Supervisor in Charge (SIC) on 04/04/23 at 3:15pm.</p> <p>Refer to telephone interview with a Pharmacist at the facility's contracted pharmacy on 04/04/23 at 3:45pm.</p> <p>Refer to interview with the Administrator on 04/04/23 at 4:15pm.</p> <p>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.</p>	C 330		
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C 330	<p>Continued From page 6</p> <p>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.</p> <p>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".</p> <p>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.</p> <p>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.</p>	C 330			

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C 330	<p>Continued From page 7</p> <p>-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".</p> <p>Review of Resident #1's March 2023 4:30pm FSBS log revealed:</p> <p>-A typed entry for Novolog units/mL vial 20 units before supper reduce by 4 units if FSBS under 90.</p> <p>-There was a handwritten entry dated 03/16/23, reduce by 12 units if FSBS under 90.</p> <p>-There were three occurrences when Resident #1's FSBS was under 90.</p> <p>-On 03/06/23, Resident #1's FSBS was 68 and 16 units of insulin were documented as administered.</p> <p>-On 03/09/23, Resident #1's FSBS was 87 and 16 units were documented as administered.</p> <p>-On 03/13/23, Resident #1's FSBS was 74 and 16 units were documented as administered.</p> <p>-Resident #1's FSBS at 4:30pm and the amounts of insulin administered were documented from 03/01/23 through 03/31/23.</p> <p>Refer to interview with Resident #1 on 04/04/23 at 4:05pm.</p> <p>Refer to interview with the SIC on 04/04/23 at 3:15pm.</p> <p>Refer to telephone interview with a Pharmacist at the facility's contracted pharmacy on 04/04/23 at 3:45pm.</p> <p>Refer to interview with the Administrator on 04/04/23 at 4:15pm.</p> <p>Attempted telephone interview with Resident #1's physician on 04/04/23 at 4:20pm was</p>	C 330		

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C 330	<p>Continued From page 8</p> <p>unsuccessful.</p> <p>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.</p> <p>Interview with the SIC on 04/04/23 at 3:15pm revealed:</p> <ul style="list-style-type: none"> -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. <p>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.</p> <p>Interview with the Administrator on 04/04/23 at 4:15pm revealed:</p> <ul style="list-style-type: none"> -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		

FACILITY was Given New Order from VA on ORDER:

Date	FSBS Result	Pre-Meal Units Given	Was FSBS Under 90?	Area Given	Schedule Insulin	MT/SIC INT Here
1			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
2			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
3			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
4			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
5			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
6			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
7			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
8			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
9			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
10			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
11			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
12			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
13			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
14			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
15			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
TURN OVER TO BACK SIDE			() Yes Reduced by _____ Units			
			() FSBS WAS NOT UNDER 90			

Blood Sugar Less than 60
 If Resident is unresponsive and unable to swallow immediately call 911 and initiate emergency response with EMS. If Resident is responsive and able to safely swallow Call Dr. Ibrahim/Elizabeth Scism NP and hold insulin (if he/she receive it). Give 2 tablespoon of sugar with 8oz of Orange Juice and encourage resident to eat a small snack. Re check BS in 30mins If still less than 60 repeat with Give 2 tablespoon of sugar with 8oz of Orange Juice and call Dr. Ibrahim/Elizabeth Scism NP and Notify EMS to eval further.

Order Confirmed and Checked
 BY: SIC
 New Order Faxed/Text to Bernice/Dr.Ibrahim
 or Beth Scism NP and Faxed to Pharmacy

Effective 4-5-23 Please Inform Administrator Immediately VIA Fax/Phone of any FSBS Reading UNDER 100
 FAX FSBS Weekly on Fridays to 704-406-9372

MONTH: APRIL YEAR: 2023

NOVOLOG SCHEDULE INSULIN BEFORE MEALS

PREMEAL READING CORRECTIONS

PHYSICIAN ORDER: Novolog 31u SQ Before Lunch
Reduce by 12u Under 90
Correction Premeal Reading Lunch
150-200=4U Over 201=5 Reduce by 8u Under 90

11:30AM-LUNCH
 Schedule Novolog- Correction Premeal Reading

TURN OVER TO BACK

FACILITY was GIVEN NEW ORDER from VA on _____ ORDER: _____

Date	FSBS Result	Pre-Meal Units Given	Was FSBS Under 90?	Area Given	Schedule Insulin	MT/SIC INT Here
16			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
17			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
18			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
19			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
20			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
21			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
22			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
23			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
24			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
25			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
26			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
27			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
28			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
29			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
30			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			
31			() Yes Reduced by _____ Units () FSBS WAS NOT UNDER 90			

Blood Sugar Less than 60
 If Resident is unresponsive and unable to swallow immediately call 911 and initiate emergency response with EMS. If Resident is responsive and able to safely swallow Call Dr. Ibrahim/Elizabeth Scism NP and hold insulin (if he/she receive it). Give 2 tablespoons of sugar with 8oz of Orange Juice and encourage resident to eat a small snack. Re check BS in 30mins if still less than 60 repeat with Give 2 tablespoons of sugar with 8oz of Orange Juice and call Dr. Ibrahim/Elizabeth Scism NP and Notify EMS to eval further.

Order Confirmed and Checked
 By: SIC

New Order Faxed/Text to Bernice/Dr. Ibrahim or Beth Scism NP- and Faxed to Pharmacy
Effective 4-5-23 Please Inform Administrator Immediately VIA Fax/Phone of any FSBS Reading UNDER 100
FAX FSBS Weekly on Fridays to 704-406-9372

MONTH: **APRIL** YEAR: 20**23**

NOVOLOG SCHEDULE INSULIN BEFORE MEALS

PREMEAL READING CORRECTIONS

Novolog 41u SQ Before Breakfast

PHYSICIAN ORDER: Reduce by 4u Under 90

Correction Premeal Reading Breakfast

150-200=6U Over 201=8 Reduce by 8u Under 90

6:30AM-BREAKFAST

Schedule Novolog- Correction Premeal Reading