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C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey from 04/18/23 to 04/19/23 with an exit conference via telephone on 04/20/23.	C 000		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 1 of 1 staff (the Administrator) who administered medications, including insulin, had the required 15 hour medication aide training. The findings are: Review of the Administrator's personnel record revealed: -There was a hire date of 09/10/22. -The Administrator was the medication aide (MA).	C 131		

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C 131	Continued From page 1 -There was no documentation that the 5 hour, 10 hour or 15 hour Medication Aide Training were completed. -The Medication Clinical Skills Validation checklist was completed and dated 07/28/22. -There was documentation the Administrator had completed three hour continuing education hour class on diabetes care and insulin administration. -There was documentation the Administrator completed a medication aide test on 10/30/18. Review of Resident #1's January 2023 medication administration record (MAR) revealed: -The Administrator administered medications and insulin from 01/26/23 to 01/31/23 and checked FSBSs from 01/28/23 to 01/30/23. including insulin and checked FSBS 15 times from 01/29/23 to 01/30/23. Review of Resident #1's February 2023 MAR revealed the Administrator administered medications including insulin and checked FSBSs from 02/01/23 to 02/28/23. Review of Resident #1's March 2023 MAR revealed the Administrator administered medications including insulin and checked FSBSs from 03/01/23 to 03/31/23. Review of Resident #1's April 2023 MAR revealed the Administrator administered medications including insulin and checked FSBSs from 04/01/23 to 04/18/23. Interview with the Administrator on 04/19/23 at 3:10pm revealed: -She did not have documentation that she took the 5 hour, 10 hour or 15 hour medication aide trainings. -She passed the MA test on 10/30/18.	C 131		

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C 131	Continued From page 2 -A registered nurse (RN) checked off her medication administration skills validation form on 07/28/22. -The same RN checked off her skills and competency evaluation on 07/28/22. Refer to Tag C 330 10A NCAC 13G .1004(a) Medication Administration (Type A1 Violation). Refer to Tag C 346 10A NCAC 13G .1004(n) Medication Administration. _____ The facility failed to ensure the only staff who performed FSBS and administered medications, including insulin, received the required 5 and 10 hour or 15 hour medication aide training. The facility's failure to ensure the Administrator was properly trained prior to administering medications independently was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 04/18/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 4, 2023.	C 131		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or moving into a family care home, the administrator, all other staff, and any persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the	C 140		

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C 140	Continued From page 3 Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. (b) There shall be documentation on file in the family care home that the administrator, all other staff, and any persons living in the family care home are free of tuberculosis disease. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on record reviews, and interviews the facility failed to ensure 1 of 1 staff (the Administrator) had documentation of a completed Tuberculosis (TB) screening in compliance with control measures adopted by the Commission for Public Health. The findings are: Review of the Administrators personnel record revealed: -The Administrator was hired on 09/10/22 as the Administrator and medication aide (MA). -There was documentation that the Administrator had a TB skin test completed on 02/06/89. -There was documentation on 02/13/89 that the Administrator had a 20-millimeter area where the TB skin test was administered, and the Administrator needed a chest x-ray completed. -There was documentation from a local hospital physician dated 02/14/89 that the Administrator received a TB skin test 8 days ago (02/06/89) and the site of the test was still 2 centimeters, a chest x-ray in October 1988 showed a small area of inflammation. -A chest x-ray was completed on 02/13/89 and was unchanged with no acute infiltrate. -The local hospital documentation on 02/14/89 revealed that the Administrator had a strongly positive TB skin test, possibly a new conversion	C 140		

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C 140	Continued From page 4 since October 1988 without any evidence of active infection. -There was no documentation of TB symptom screening upon hire. Interview with the Administrator on 04/18/23 at 2:06pm revealed she had not completed a TB screening because she had a false positive in the past and did not require a TB screening.	C 140		
C 174	10A NCAC 13G .0505(1)(2) Training On Care Of Diabetic Residents 10A NCAC 13G .0505 Training On Care Of Diabetic Residents A family care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; appropriate administration times; and (g) sliding scale insulin administration. This Rule is not met as evidenced by:	C 174		

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C 174	Continued From page 5 Based on interviews and record reviews, the facility failed to ensure 1 of 1 staff (the medication aide (MA)/Administrator) sampled who administered insulin received training on the care of diabetic residents in accordance with the rule prior to administering insulin to residents. The findings are: Review of the MA/Administrators personnel record revealed: -There was a hire date of 09/10/22. -There was no documentation of the 5 hour and 10 hour or 15 hour Medication Aide Trainings were completed. -She completed a medication aide test on 10/30/18. -The Medication Clinical Skills Validation checklist was completed and dated 07/28/22. -There was documentation she had completed an online three hour continuing education hour class from the facility's contracted pharmacy on diabetes care and insulin administration on 02/03/23. Review of a residents January 2023 medication administration record (MAR) revealed: -The MA/Administrator checked FSBS 15 times from 01/29/23 to 01/30/23. -The MA/Administrator administered 2 units of Novolog (a short-acting insulin used to treat high blood sugars) on 01/28/23 at 8:00am. Review of a residents February 2023 MAR revealed the MA/Administrator checked FSBS 63 times and administered insulin 59 times from 02/01/23 to 02/28/23. Review of a residents March 2023 MAR revealed the MA/Administrator checked FSBS 81 times	C 174		

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C 174	Continued From page 6 and administered insulin 97 times from 03/01/23 to 03/31/23. Review of a residents April 2023 MAR revealed the MA/Administrator checked FSBS 49 times and administered insulin 70 times from 04/01/23 to 04/18/23. Interview with the MA/Administrator on 04/19/23 at 3:10pm revealed: -She completed an online diabetic training course for three continuing education hours on 02/03/22 with the facility's contracted pharmacy. -She received training from her nurse consultant on how to administer insulin and complete FSBS. -She had a difficult time understanding the sliding scale insulin (SSI) she needed to follow for a resident. -She understood that if the resident's FSBS was already low that administering a short-acting insulin would drop his FSBS even further and could be dangerous because it would cause the resident's FSBS to become too low. -She should have called her nurse consultant or the primary care provider (PCP) when she realized she had difficulties understanding how to administer the correct amount of insulin for a resident. Refer to Tag C 330 10A NCAC 13G .1004(a) Medication Administration (Type A1 Violation).	C 174		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease	C 202		

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C 202	Continued From page 7	C 202		

in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 1 of 1 resident sampled (#1) had been tested for tuberculosis (TB) testing in compliance with control measures adopted by the Commission for Health Services.

The findings are:

Review of Resident #1's current FL-2 dated 01/23/23 revealed diagnoses included diabetes, hyperglycemia (high blood sugar), unspecified convulsions, and cerebral infarction (stroke).

Review of Resident #1's Resident Register revealed an admission dated 01/25/23 and the resident was admitted from a skilled nursing facility.

Review of Resident #1's facility record revealed:
-There was a tuberculosis (TB) skin test on 09/10/21 and read as negative on 09/12/21.
-There was no documentation of a second step TB skin test.

Interview with the medication aide (MA)/Administrator on 04/18/23 at 2:06pm revealed:
-Resident #1 did not have a second TB skin test completed.
-She had forgotten to take the resident needed a

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C 202	Continued From page 8 second TB skin test and had forgotten to call the local health department (LHD) to schedule his second test. -She was responsible for ensuring the resident had a second TB skin test.	C 202		
C 240	10A NCAC 13G .0802(e) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 1 of 1 resident (#1) had the resident assessment signed within 15 days of assessment. The findings are: Review of Resident #1's current FL-2 dated 01/23/23 revealed diagnoses included diabetes, hyperglycemia (high blood sugar), unspecified convulsions, and cerebral infarction (stroke). Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 01/25/23. Review of Resident #1's care plan revealed:	C 240		

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C 240	Continued From page 9 -The care plan was completed and signed by the facility's nurse consultant on 01/25/23. -The primary care provider (PCP) signed the care plan on 03/22/23. Interview with the medication aide (MA)/Administrator on 04/18/23 at 2:06pm revealed: -Resident #1's first visit with his PCP was 02/22/23. -She forgot that she needed to provide the PCP with the resident's care plan to review and sign. -She knew she was late getting the care plan signed for Resident #1. -She was responsible for ensuring the PCP signed a resident's care plan within 30 days of admission.	C 240		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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: TYPE A1 VIOLATION Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 1 resident (#1) with a diagnosis of diabetes related to failing to contact the primary care provider (PCP) or emergency medical services (EMS) for a finger stick blood sugar (FSBS) of 32, contacting the PCP per parameters and scheduling a podiatry appointment (#1). The findings are:	C 246		

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C 246	Continued From page 10 Review of Resident #1's current FL-2 dated 01/23/23 revealed diagnoses included diabetes, hyperglycemia (high blood sugar), cerebral infarction (stroke) and seizures. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 01/25/23. Review of Resident #1's care plan dated 01/25/23 revealed the resident required supervision for bathing, toileting, ambulation, and bathing. 1. Review of a physician's order dated 01/26/23 revealed an order for Novolog insulin to inject 12 units with meals at 8:00am, 12:00pm, and 5:00pm and follow the SSI parameters, FSBS before meals; sliding scale insulin (SSI) FSBS 176-210 administer 1 units of insulin, FSBS 211-245 administer 2 units of insulin, FSBS 246-280 administer 3 units of insulin, FSBS 281-315 administer 4 units of insulin, FSBS 316-350 administer 4 units of insulin, 351-385 administer 6 units of insulin, FSBS 386-420 administer 7 units of insulin, and FSBS over 420 call the PCP. Review of Resident #1's January 2023 medication administration record (MAR) revealed: -There was an entry for Novolog insulin check FSBS before meals; SSI FSBS 176-210 administer 1 units of insulin, FSBS 211-245 administer 2 units of insulin, FSBS 246-280 administer 3 units of insulin, FSBS 281-315 administer 4 units of insulin, FSBS 316-350 administer 4 units of insulin, 351-385 administer 6 units of insulin, FSBS 386-420 administer 7 units of insulin, and FSBS over 420 call the PCP. -A FSBS of 46 was documented on 01/30/23 at	C 246		

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C 246	Continued From page 11 8:00am. -A FSBS of 32 was documented on 01/30/23 at 8:30am. -A FSBS of 85 was documented on 01/30/23 at 9:44am, and there was documentation plain sugar was administered. -A FSBS of 61 was documented on 01/30/23 at 11:00am and there was documentation plain sugar was administered. -A FSBS of 54 was documented on 01/30/23 at 1:27pm. -A FSBS of 35 was documented on 01/30/23 at 4:15pm. -A FSBS of 58 was documented on 01/30/23 at 5:00pm. -There was no documentation available that that medication aide (MA)/Administrator had contacted emergency medical services (EMS) or the resident's PCP to report a FSBS as low as 32 on 01/30/23. Interview with the MA/Administrator on 04/19/23 at 12:32pm revealed: -She contacted her nurse consultant when Resident #1's FSBS was low on 01/30/23. -The nurse consultant instructed her to give the resident a tablespoon of sugar to help bring his sugar levels up. -She did not think to call EMS or the PCP because she thought the resident would be okay once she gave him sugar. -She should have contacted EMS when the resident's FSBS was low. -She had not noticed the order on resident's physician orders or the medication administration record (MAR) to contact the PCP if the resident's FSBSs were too low or too high. -She received training on medication administration and proper documentation from an account executive with the facility's contracted	C 246		

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pharmacy but did not realize that she needed to notify the resident's PCP if his FSBSs were too low or too high.
-She was responsible for following the PCP orders and should have followed the parameters..
-Resident #1 could have become unresponsive when his FSBS got too low.

Telephone interview with the facility's nurse consultant on 04/19/23 at 11:51am revealed:
-The MA/Administrator called her on 01/30/23 when Resident #1's FSBS dropped too low.
-She did not instruct the MA/Administrator to call 911.
-She instructed the MA/Administrator to administer a tablespoon of sugar to the resident and to recheck his FSBS.
-She explained to the MA/Administrator that if the resident's FSBS was less than 60 he needed a protein based snack or a tablespoon of sugar.
-She thought the MA/Administrator notified the PCP about his low FSBS.
-She was not aware that the MA/Administrator did not call 911 when his FSBS became so low.
-The MA/Administrator had requested her assistance with Resident #1 since he was her first admission and called her with any questions.
-Resident #1 was in danger of losing consciousness due to his low FSBS on 01/30/23 and the MA should have contacted 911 before she contacted her.

Telephone interview with Resident #1's PCP on 04/20/23 at 4:03pm revealed:
-The MA/Administrator should be aware of the difference in a FSBS of 47 and 200.
-A FSBS of 32 or lower placed the resident at an imminent risk of becoming non responsive immediately and at risk for death.
-The MA/Administrator should have called 911

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when the resident's FSBS was down to 32 to protect the resident from a coma or death.
-The MA/Administrator should have known to give the resident sugar tablets or orange juice until emergency medical services (EMS) arrived to ensure his safety.

2. Review of a physician order dated 02/22/23 revealed:
-Novolog insulin 12 units with meals at 8:00am, 12:00pm, and 5:00pm was changed to Novolog 8 units to be administered three times a day with meals; if the resident did not want to eat a meal hold his Novolog.
-Do not give Novolog if FSBS is less than 150.
-FSBS less than 70 or greater than 300 call the PCP.

Review of Resident #1's February 2023 (MAR) from 02/22/23 to 02/28/23 revealed:
-There was a entry for Novolog insulin 12 units to be administered three times a day with meals; if the resident did not want to eat a meal hold his Novolog.
-Do not give Novolog if FSBS is less than 150.
-FSBS less than 70 or greater than 300 call the PCP.
-A FSBS of 310 was documented on 02/26/23 at 12:00pm.
-A FSBS of 371 was documented on 02/28/23 at 12:00pm.
-There was no documentation available that that medication aide (MA)/Administrator had contacted the resident's PCP to report a FSBS over 300.

Review of Resident #1's March 2023 (MAR) revealed:
-There was a entry for Novolog insulin 12 units to be administered three times a day with meals; if

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANDS THAT CARES	5209 ACRES ROAD ELM CITY, NC 27822

(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 246	Continued From page 14	C 246		

the resident did not want to eat a meal hold his Novolog.
-Do not give Novolog if FSBS is less than 150.
-FSBS less than 70 or greater than 300 call the PCP.
-A FSBS of 332 was documented 03/01/23 at 12:00pm.
-A FSBS of 332 was documented 03/01/23 at 5:00pm.
-A FSBS of 335 was documented 03/04/23 at 5:00pm.
-A FSBS of 433 was documented 03/05/23 at 5:00pm.
-A FSBS of 418 was documented 03/07/23 at 12:00pm.
-A FSBS of 459 was documented on 03/10/23 at 5:00pm.
-A FSBS of 390 was documented on 03/15/23 at 8:30am.
-A FSBS of 358 was documented on 03/24/23 at 12:00pm.
-There was no documentation available that that MA/Administrator had contacted the resident's PCP to report a FSBS over 300 eight times in March 2023.

Review of Resident #1's April 2023 (MAR) revealed:
-There was a entry for Novolog insulin 12 units to be administered three times a day with meals; if the resident did not want to eat a meal hold his Novolog.
-Do not give Novolog if FSBS is less than 150.
-FSBS less than 70 or greater than 300 call the PCP.
-A FSBS of 560 was documented 04/01/23 at 2:30pm.
-A FSBS of 62 was documented on 04/07/23 at 8:00am.
-There was no documentation available that that

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C 246	Continued From page 15 MA/Administrator had contacted the resident's PCP to report a FSBS over 300 and a FSBS under 70. Interview with the facility's nurse consultant on 04/19/23 at 11:51am revealed: -She usually visited the facility a few times a week but had not been in 2 to 3 weeks. -She had provided education to the MA/Administrator on how to read PCP orders, MARS, SSI parameters, and to document the resident's FSBSs and amount of insulin administered. -She provided education to the MA/Administrator on documenting any communication with the facility's contracted pharmacy, the PCP and any other providers. -She had reminded the MA/Administrator to contact her by phone if she had any questions about PCP orders. -The MA/Administrator was expected to understand how to follow PCP orders and it was important to notify the PCP if the resident FSBSs were too low or too high. -She expected the MA/Administrator to follow the PCP orders to prevent the resident from becoming hypoglycemic or hyperglycemic and notify the PCP per the parameter orders. Telephone interview with Resident #1's PCP on 04/20/23 at 4:03pm revealed: -The MA/Administrator had not notified him that Resident #1 had FSBS's that were under 70 and over 300. -He expected the MA/Administrator to follow his orders and to notify him if the residents FSBS were under 70 or above 300 so he could manage his diabetes better. -He met with the MA/Administrator on 02/22/23 when Resident #1 had his first appointment.	C 246		

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C 246	Continued From page 16 -He provided her with education on hyperglycemia (when blood sugars are high) and hypoglycemia (when blood sugars are too low). -He reinforced with the MA/Administrator that he would rather her call anytime she had a question to ensure Resident #1 received the correct amount of insulin. -He reminded her that he was available to provide educational assistance on the administration of the resident's insulin to prevent him from experiencing hypoglycemia and hyperglycemia. -Resident #1 was at an increased risk of hypoglycemia if the MA/Administrator administered Novolog when his FSBS was below 70. -The resident was at an increased risk of hyperglycemia if the MA/Administrator did not contact him to provide an update of his high FSBS. -The MA/Administrator was expected to follow his orders so he could properly manage the resident's diabetes. -Resident #1 was at risk of long term health problems such as congestive heart failure, diabetic neuropathy and long term damage to his kidneys when his blood sugar was too high. -Resident #1 was at a risk of passing out immediately, becoming nonresponsive and could die if his blood sugar became too low. 3. Observation of Resident #1 on 04/18/23 at 9:31am revealed: -The resident was lying on his bed watching television. -Some of his toenails were overgrown. -The big toe on his left foot had a jagged edge and was ¼ inch long extended from his toe. -The second toe on his left foot was ¼ inch long extended from his toe. -The fourth toe on his left foot was ½ inch long	C 246		

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extended from his toe.
-The fifth toe on his left foot crossed over the base of the fourth toe.
-The big toe on his right foot was yellow, thick, and jagged.
-The second toe on his right foot was ½ inch long extended from his toe.
-The third toe on his right foot was ¼ inch long extended from his toe.
-The fourth toe on his right foot was jagged and ¼ inch long extended from his toe.
-The fifth toe on his right foot was yellow and thick.

Interview with Resident #1 on 04/18/23 at 9:31am revealed:
-He had not been seen by a podiatrist in two years.
-He did not want the medication aide medication aide (MA)/Administrator to cut his toenails.
-He did not like to get his toenails cut.
-He denied pain when he walked.

Interview with the MA/Administrator on 04/18/23 at 9:34am revealed:
-She had asked Resident #1 if she could trim his toenails, but he refused.
-She thought she could trim the resident's toenails and did not realize he needed to be seen by a podiatrist.
-She was not aware of a referral for him to be seen by a podiatrist.
-She had not contacted the resident's primary care provider (PCP) to inform him about the residents' long toenails and refusal to allow her to cut his toenails.
-She did not realize that she was responsible for contacting the resident's PCP to provide an update on the resident's toenails and need for a podiatry referral.

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C 246	Continued From page 18 Telephone interview with Resident #1's PCP on 04/20/23 at 4:03pm revealed: -He saw the resident for a regular PCP visit on 02/22/23 and made a referral to a local podiatrist at that time. -The facility had not ensured the referral to the podiatrist took place. -The MA/Administrator should have called his office to let him know that the podiatry office had not contacted her about the resident's referral. -Resident #1 needed to be seen by a podiatrist due to his diabetes. -He was placed at an increased risk of wounds on his feet that he may not feel due to his diabetes, which could lead to infection and possibly amputation. _____ The facility failed to notify emergency medical services (EMS) or the resident's primary care provider (PCP) when his finger stick blood sugars (FSBS) became dangerously low which could have resulted in death and failed to notify the PCP when FSBS exceeded the ordered parameters and the resident needed to be seen by a podiatrist. The failure resulted in serious neglect to the resident and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/18/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 20, 2023.	C 246		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care	C 249		

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C 249	Continued From page 19 10A NCAC 13G .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 observations, interviews, and record reviews, the facility failed to perform finger stick blood sugars (FSBS) three times a day for 1 of 1 resident (#1). The findings are: Review of Resident #1's current FL-2 dated 01/23/23 revealed: -Diagnoses included diabetes, hyperglycemia (high blood sugar), cerebral infarction (stroke) and seizures. -There was an order for Novolog insulin, check fingerstick blood sugar (FSBS) before meals; sliding scale insulin (SSI) FSBS 176-210 administer 1 unit of insulin, FSBS 211-245 administer 2 units of insulin, FSBS 246-280 administer 3 units of insulin, FSBS 281-315 administer 4 units of insulin, FSBS 316-350 administer 4 units of insulin, 351-385 administer 6 units of insulin, FSBS 386-420 administer 7 units of insulin, and FSBS over 420 call the primary care provider (PCP). Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 01/25/23.	C 249		

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C 249	Continued From page 20 a. Review of Resident #1's January 2023 medication administration record (MAR) revealed: -There was an entry for Novolog insulin check FSBS before meals; SSI FSBS 176-210 administer 1 units of insulin, FSBS 211-245 administer 2 units of insulin, FSBS 246-280 administer 3 units of insulin, FSBS 281-315 administer 4 units of insulin, FSBS 316-350 administer 4 units of insulin, 351-385 administer 6 units of insulin, FSBS 386-420 administer 7 units of insulin, and FSBS over 420 call the PCP. -There were no FSBSs recorded on 01/25/23 to 01/28/23. Refer to interview with the medication aide (MA)/Administrator on 04/19/23 at 12:32pm. Refer to interview with the facility's nurse consultant on 04/19/23 at 11:51am. Telephone interview with Resident #1's PCP on 04/20/23 at 4:03pm. b. Review of Resident #1's March 2023 (MAR) revealed: -There was an entry for Novolog insulin 12 units to be administered three times a day with meals; if the resident did not want to eat a meal hold his Novolog. -Do not give Novolog if FSBS is less than 150. -FSBS less than 70 or greater than 300 call the PCP. -There was an entry for Novolog insulin check FSBS before meals; SSI FSBS 176-210 administer 1 units of insulin, FSBS 211-245 administer 2 units of insulin, FSBS 246-280 administer 3 units of insulin, FSBS 281-315 administer 4 units of insulin, FSBS 316-350 administer 4 units of insulin, 351-385 administer 6 units of insulin, FSBS 386-420 administer 7 units	C 249		

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C 249	Continued From page 21 of insulin, and FSBS over 420 call the PCP. -There was no documentation of a FSBS on 03/01/23 at 8:00am. -There was no documentation of a FSBS on 03/02/23 at 8:00am, 12:00pm, and 5:00pm. -There was no documentation of a FSBS on 03/03/23 at 8:00am and 12:00pm. -There was no documentation of a FSBS on 03/04/23 at 8:00am and 12:00pm. -There was no documentation of a FSBS on 03/05/23 at 8:00am and 12:00pm. -There was no documentation of a FSBS on 03/06/23 at 8:00am and 12:00pm. Interview with the MA/Administrator on 04/19/23 at 12:32pm revealed: -She had forgotten to take Resident #1's FSBS a few times in January and March. -She first spoke with the resident's PCP about his FSBS's and insulin at the resident's first appointment on 02/22/23. -She had tried to contact the PCP several times with questions about the resident's insulin but had not been able to reach him. -She could not remember if she left a message for the PCP to return her calls or not. -She had not faxed questions to the PCP and did not maintain progress notes of when she attempted to contact the PCP. -She received training on medication administration and proper documentation from an account executive with the facility's contracted pharmacy but did not realize that she needed to notify the resident's PCP if his FSBSs were too low or too high. -She did not have a system in place to complete MAR and cart audits. -She was responsible for following the PCP orders.	C 249		

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C 249	Continued From page 22 Interview with the facility's nurse consultant on 04/19/23 at 11:51am revealed: -She usually visited the facility a few times a week but had not been in 2 to 3 weeks. -She had provided education to the MA/Administrator on how to read PCP orders, MARS, SSI parameters, and to document the resident's FSBSs. -She provided education to the MA/Administrator on documenting any communication with the facility's contracted pharmacy, the PCP and any other providers. -She had reminded the MA/Administrator to contact her by phone if she had any questions about PCP orders. -The MA/Administrator was expected to understand how to follow PCP orders, check FSBSs as ordered and document FSBS checks. -She expected the MA/Administrator to follow the PCP orders to prevent the resident from becoming hypoglycemic or hyperglycemic. Telephone interview with Resident #1's PCP on 04/20/23 at 4:03pm revealed: -He expected the MA/Administrator to follow his orders and check Resident #1's FSBSs prior to administering SSI. -He expected the MA/Administrator to check the residents FSBS prior to administering insulin to prevent the resident from passing out immediately, becoming unresponsive or dying if his blood sugar became too low. -He met with the MA/Administrator on 02/22/23 when Resident #1 had his first appointment. -He provided her with notes to help her understand the importance of administering the correct amount of insulin based on the residents' FSBS. -He provided her with education on hyperglycemia (when blood sugars are high) and	C 249		

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C 249	Continued From page 23 hypoglycemia (when blood sugars are too low). -He reminded her that he was available to provide educational assistance on the administration of the resident's insulin to prevent him from experiencing hypoglycemia and hyperglycemia. -Administering insulin when the residents FSBS was already low placed the resident at greater health risks.	C 249		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure foods being stored and served to residents were protected from contamination related to observations of expired, unlabeled, and undated foods. The findings are:	C 257		

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C 257	Continued From page 24 Observation of the facility's refrigerator on 04/18/23 at 9:45am revealed: -There was one manufacturer package of a 12 ounce bag of tossed salad with brown and slimy residue at the bottom of the bag. -There one manufacturer package of a 12 ounce bag of three romaine hearts lettuce with brown and slimy residue on the lettuce. -There was an uncovered stick of butter on the top shelf of the refrigerator door, the butter was exposed and was sitting on top of the original wrapper. Observation of the facility's freezer on 04/18/23 at 9:49am revealed: -There were 2 quart sized storage bags with frozen chicken breasts that were not labeled with the date or with the item stored on the top shelf. -There was one 2 quart sized storage bag with frozen chicken on the second shelf that was not labeled with the date or with the item. -There were three pint sized storage bags of chopped purple onions and three pint sized storage bags of chopped white onions on the bottom shelf. -The six bags of frozen onions were not labeled with a date or with the item stored in the storage bags. Observation of the facility's pantry on 04/18/23 at 9:53am revealed: -There was a plastic container on the top shelf from a local grocery store that contained 4 cookies with a store label that had a sell by date of 02/26/23. -There was a plastic container on the third shelf from a local grocery store that contained 3 cookies with a store label that had a sell by date of 02/28/23. -There was an 8 ounce opened bag of ginger	C 257		

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C 257	Continued From page 25 snap cookies on the third shelf that was unsecured. Interview with the medication aide (MA)/Administrator on 04/18/23 at 9:57am revealed: -She did not realize that items stored in the freezer needed to be labeled with what food item was inside the storage bag and the date it was stored. -She had forgotten that she should not store vegetables below meats in the freezer. -She meant to dispose of the salad in the refrigerator but forgot to remove it. -She should have checked the expiration date on items in the pantry and thrown food away that had expired. -She was responsible for ensuring all foods were stored correctly to prevent contamination and to protect the resident from becoming sick.	C 257		
C 292	10A NCAC 13G .0905 (d) Activities Program 10A NCAC 13G .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure residents were offered activities designed to promote the residents' active involvement.	C 292		

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C 292	Continued From page 26 The findings are: Review of the activities calendar posted in the kitchen on 04/18/23 at 9:14am revealed: -There was an activity calendar posted for the month of March 2023. -There was not an activity calendar posted or available for the month of April 2023. Observation of activity supplies in the family room on 04/18/23 at 10:00am included a television and two puzzles. Review of the activities calendar posted in the kitchen on 04/18/23 listed activities on the fourth Tuesday as bible reading from 10:00am to 11:00am and primp and pamper from 2:00pm to 3:00pm. Observation of the facility from 9:31am to 12:30pm on 04/18/23 from revealed: -There was one resident in the facility. -The resident stayed in his bedroom with the door closed and a television on in his room. Observation of the facility from 2:00pm to 4:30pm revealed the resident stayed in his bedroom with the door closed watching television and left his room two times to use the restroom. Interview with a Resident #1 on 04/18/23 at 9:27am revealed: -He enjoyed resting and watching television but wanted to do more activities. -He enjoyed going on outings in the community and wished they went on outings more often. -He was not sure what primp and pamper was for the activity for today. -The Administrator cut his fingernails every few weeks.	C 292		

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C 292	Continued From page 27 Interview with the medication aide (MA)/Administrator on 04/18/23 at 3:00pm revealed: -She had forgotten to post the April 2023 activity calendar. -The activities were the same for each month unless they had an outing. -She took the resident with her to the grocery store, and he enjoyed shopping. -She was completing her training for activity director through an online course. -She had planned to purchase more activity supplies for the home and knew Resident #1 enjoyed anything related to sports. -She had not made the time to purchase additional activity supplies for the home.	C 292		
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 and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 1 resident (#1) with medications used to treat diabetes and a	C 330		

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medication used to treat seizures (#1).

The findings are:

Review of an undated facility policy for medication administration on 04/19/23 revealed:
-The facility shall ensure that the preparation and administration of medication by staff are in accordance with orders by a licensed prescribing practitioner which are maintained in the resident's record.
-The facility will ensure that medications are administered within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations.
-The resident's medication administration record (MAR) shall be accurate and include the date and time of administration, documentation of any omission of medications and the reason for the omission, and name or initials of the person administering the medication.

Review of Resident #1's current FL-2 dated 01/23/23 revealed diagnoses included diabetes, hyperglycemia (high blood sugar), cerebral infarction (stroke) and seizures.

1. Review of a physician's order dated 01/26/23 revealed there was an order for Novolog insulin (a short-acting insulin used to treat high blood sugars) to inject 12 units with meals at 8:00am, 12:00pm, and 5:00pm and follow the sliding scale insulin (SSI) parameters.

Review of Resident #1's January 2023 medication administration record (MAR) revealed:
-There was an entry for Novolog insulin to inject 12 units with meals at 8:00am, 12:00pm, and 5:00pm and follow the SSI parameters.
-Novolog 12 units was not documented as

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administered on 01/26/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/26/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/26/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/27/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/27/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/27/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/28/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/28/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/28/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/29/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/29/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/29/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/30/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/30/23 at 12:00pm, when 12

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units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/30/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 01/31/23 at 8:00am, when 12 units of Novolog should have been administered.
-The FSBS range from 01/26/23 to 01/31/23 was 32 to 211.

Review of Resident #1's February 2023 MAR revealed:
-There was an entry for Novolog insulin to inject 12 units with meals at 8:00am, 12:00pm, and 5:00pm and follow the SSI parameters.
-Novolog 12 units was not documented as administered on 02/01/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/01/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/01/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/02/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/02/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/02/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/03/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/03/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as

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C 330	Continued From page 31	C 330		

administered on 02/03/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/04/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/04/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/04/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/05/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/05/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/05/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/06/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/06/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/06/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/07/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/07/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/07/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/08/23 at 8:00am, when 12

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units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/08/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/08/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/09/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/09/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/09/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/10/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/10/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/10/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/11/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/11/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/11/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/12/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/12/23 at 12:00pm, when 12 units of Novolog should have been administered.

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C 330	Continued From page 33 -Novolog 12 units was not documented as administered on 02/12/23 at 5:00pm, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as administered on 02/13/23 at 8:00am, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as administered on 02/13/23 at 12:00pm, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as administered on 02/13/23 at 5:00pm, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as administered on 02/14/23 at 8:00am, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as administered on 02/14/23 at 12:00pm, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as administered on 02/14/23 at 5:00pm, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as administered on 02/15/23 at 8:00am, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as administered on 02/15/23 at 12:00pm, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as administered on 02/15/23 at 5:00pm, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as administered on 02/16/23 at 8:00am, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as administered on 02/16/23 at 12:00pm, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as administered on 02/16/23 at 5:00pm, when 12 units of Novolog should have been administered. -Novolog 12 units was not documented as	C 330		

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administered on 02/17/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/17/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/17/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/18/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/18/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/18/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/19/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/19/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/19/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/20/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/20/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/20/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/21/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/21/23 at 12:00pm, when 12

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units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/21/23 at 5:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/22/23 at 8:00am, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/22/23 at 12:00pm, when 12 units of Novolog should have been administered.
-Novolog 12 units was not documented as administered on 02/22/23 at 5:00pm, when 12 units of Novolog should have been administered.
-FSBS's ranged from 129 to 308 from 02/23/23 to 02/28/23.

Interview with the medication aide (MA)/Administrator on 04/18/23 at 3:24pm revealed:
-She talked with the resident's primary care provider (PCP) at his first appointment on 02/22/23.
-She explained to the PCP that she had a difficult time understanding his Novolog and SSI.
-She did not inform the PCP that Resident #1's FSBS became dangerously low in January 2023.
-She did not ask the PCP about what to do if the resident's FSBS became low again like it did in January 2023.

Refer to interview with the MA/Administrator on 04/19/23 at 12:32pm.

Refer to telephone interview with the facility's nurse consultant on 04/19/23 at 11:51am.

Refer to telephone interview with Resident #1's PCP on 04/20/23 at 4:03pm.

2. Review of a physician order dated 02/22/23

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C 330	Continued From page 36 revealed: -Novolog insulin 12 units with meals at 8:00am, 12:00pm, and 5:00pm was changed to Novolog 8 units to be administered three times a day with meals; if the resident did not want to eat a meal hold his Novolog. -Do not give Novolog if FSBS is less than 150. -FSBS less than 70 or greater than 300 call the PCP. Telephone interview with Resident #1's PCP on 04/20/23 at 4:03pm revealed: -He met with the MA/Administrator on 02/22/23 when Resident #1 had his first appointment and realized she had a difficult time understanding the SSI. -He discontinued the SSI order and changed the resident's Novolog from 12 units a day with meals to 8 units a day with meals; do no administer Novolog 8 units if FSBS is less than 150. -He added parameters for her to contact him if the resident's FSBSs were less than 70 or greater than 300 to contact him. -He provided her with notes to help her understand the importance of administering the correct amount of insulin based on the residents' FSBS. -He provided her with education on hyperglycemia (when blood sugars are high) and hypoglycemia (when blood sugars are too low). Review of Resident #1's February 2023 MAR from 02/23/23 to 02/28/23 revealed: -There was an entry for Novolog insulin to inject 12 units to be administered three times a day with meals; if the resident did not want to eat a meal hold his Novolog. -Do not give Novolog if FSBS is less than 150. -FSBS less than 70 or greater than 300 call the PCP.	C 330		

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C 330	Continued From page 37 -No Novolog was documented as administered on 02/23/23 at 8:00am, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 02/23/23 at 12:00pm, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 02/23/23 at 5:00pm, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 02/24/23 at 8:00am, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 02/25/23 at 8:00am, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 02/26/23 at 8:00am, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 02/27/23 at 8:00am, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 02/27/23 at 12:00pm, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 02/27/23 at 5:00pm, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 02/28/23 at 8:00am, when 8 units of Novolog should have been administered. -FSBS's ranged from 127 to 371 from 02/23/23 to 02/28/23. Review of Resident #1's March 2023 MAR revealed: -There was an entry for Novolog insulin to inject 12 units to be administered three times a day with meals; if the resident did not want to eat a meal hold his Novolog. -Do not give Novolog if FSBS is less than 150.	C 330		

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C 330	Continued From page 38 -FSBS less than 70 or greater than 300 call the PCP. -No Novolog was documented as administered on 03/06/23 at 12:00pm, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 03/07/23 at 8:00am, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 03/08/23 at 12:00pm, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 03/30/23 at 12:00pm, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 03/30/23 at 5:00pm, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 03/31/23 at 12:00pm, when 8 units of Novolog should have been administered. -No Novolog was documented as administered on 03/31/23 at 5:00pm, when 8 units of Novolog should have been administered. -FSBS's ranged from 76 to 459 from 03/01/23 to 03/31/23. Review of Resident #1's April 2023 MAR revealed: -There was an entry for Novolog insulin to inject 12 units to be administered three times a day with meals; if the resident did not want to eat a meal hold his Novolog. -Do not give Novolog if FSBS is less than 150. -FSBS less than 70 or greater than 300 call the PCP. -No Novolog was documented as administered on 04/05/23 at 12:00pm, when 8 units of Novolog should have been administered. -FSBS's ranged from 62 to 568 from 04/01/23 to 04/17/23.	C 330		

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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
C 330	Continued From page 39 Telephone interview with the pharmacist at the facility's contracted pharmacy on 04/19/23 at 10:29am revealed: -The pharmacy received an order on 02/22/23 to administer Novolog insulin 8 units three times a day with meals; if the resident did not want to eat a meal hold Novolog. -Do not give Novolog if FSBS is less than 150. -FSBS less than 70 or greater than 300 call the PCP. -There was an order for Novolog to inject 12 units with meals and follow the SSI parameters. -There was not a discontinue order for the SSI FSBSs. -There was an order for Novolog insulin check FSBS before meals; SSI FSBS 176-210 administer 1 units of insulin, FSBS 211-245 administer 2 units of insulin, FSBS 246-280 administer 3 units of insulin, FSBS 281-315 administer 4 units of insulin, FSBS 316-350 administer 4 units of insulin, 351-385 administer 6 units of insulin, FSBS 386-420 administer 7 units of insulin, scheduled for administration at 8:00am, 12:00pm, and 5:00pm, and FSBS over 420 call the PCP. Refer to interview with the MA/Administrator on 04/19/23 at 12:32pm. Refer to telephone interview with the facility's nurse consultant on 04/19/23 at 11:51am. Refer to telephone interview with Resident #1's PCP on 04/20/23 at 4:03pm. _____ Interview with the MA/Administrator on 04/19/23 at 12:32pm revealed: -She was responsible for following the PCP orders.	C 330		

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C 330	Continued From page 40 -She had a difficult time understanding the SSI parameters for Resident #1's Novolog and could not follow it. -She took Resident #1's physician order sheet and MARS to his first appointment on 02/22/23. -She first spoke with the resident's PCP about his FSBS's and insulin at the resident's first appointment on 02/22/23. -The PCP reviewed the MARS and questioned her about her understanding of the SSI parameters ordered because she was not administering the Novolog correctly per the SSI parameters. -The PCP changed Resident #1's Novolog at his appointment on 02/22/23 because she had a difficult time understanding how to read the SSI parameters and administer the correct amount of insulin. -The PCP changed his Novolog to administer 8 units with each meal and to hold the Novolog if the resident did not want to eat his meal. -She continued to administer Novolog per her understanding of the SSI parameters and was worried she was not giving the resident the correct amount of Novolog. -She had tried to contact the PCP several times with questions but had not been able to reach him, she could not remember if she left a message for the PCP to return her calls or not. -She had not faxed questions to the PCP and did not maintain progress notes of when she attempted to contact the PCP. -She received training on medication administration and proper documentation from an account executive with the facility's contracted pharmacy but continued to have a difficult time understanding the resident's FSBS and how to administer Novolog per the SSI parameters. -She did not have a system in place to complete MAR and cart audits.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 41 Interview with the facility's nurse consultant on 04/19/23 at 11:51am revealed: -She usually visited the facility a few times a week but had not been in 2 to 3 weeks. -She had provided education to the MA/Administrator on how to read physician orders, SSI parameters, determine how much Novolog to administer based on the SSI parameters and to document the resident's FSBSs and amount of Novolog administered. -She had reminded the MA/Administrator to contact her by phone if she had any questions on how to administer Novolog based on the SSI and if she had any questions about any medications. -The MA/Administrator should have contacted her or the PCP when she had difficulties understanding the SSI parameters for the resident's Novolog. -The MA/Administrator was expected to understand how to follow PCP orders and it was important that the resident receive the correct amount of Novolog to prevent further complications with his diabetes. -She expected the MA/Administrator to follow the PCP orders to prevent the resident from becoming hypoglycemic or hyperglycemic. Telephone interview with Resident #1's PCP on 04/20/23 at 4:03pm revealed: -He met with the MA/Administrator on 02/22/23 when Resident #1 had his first appointment. -He provided her with notes to help her understand the importance of administering the correct amount of insulin based on the residents' FSBS. -He provided her with education on hyperglycemia (when blood sugars are high) and hypoglycemia (when blood sugars are too low). -He reinforced with the MA/Administrator that he	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 42	C 330		

would rather her call anytime she had a question to ensure Resident #1 received the correct amount of insulin.
-He reminded her that he was available to provide educational assistance on the administration of the resident's insulin to prevent him from experiencing hypoglycemia and hyperglycemia.
-The MA/Administrator needed to ensure she administered the resident's insulin correctly to prevent the resident from becoming hypoglycemic or hyperglycemic; he specialized in the care of diabetes and was willing to assist the MA any time she had a question about the administration of the resident's insulin.
-Resident #1 was at risk of long term health problems such as congestive heart failure, diabetic neuropathy and long term damage to his kidneys when his blood sugar was too high.
-Resident #1 was at a risk of passing out immediately, becoming nonresponsive and could die if his blood sugar became too low.

3. Review of a physician's order dated 01/26/23 revealed there was an order for Novolog insulin to inject 12 units with meals at 8:00am, 12:00pm, and 5:00pm and follow the SSI parameters, FSBS before meals; SSI FSBS 176-210 administer 1 units of insulin, FSBS 211-245 administer 2 units of insulin, FSBS 246-280 administer 3 units of insulin, FSBS 281-315 administer 4 units of insulin, FSBS 316-350 administer 4 units of insulin, 351-385 administer 6 units of insulin, FSBS 386-420 administer 7 units of insulin, and FSBS over 420 call the PCP.

Review of Resident #1's January 2023 medication administration record (MAR) revealed:
-There was an entry for Novolog insulin to inject 12 units with meals at 8:00am, 12:00pm, and 5:00pm and follow the SSI parameters.

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C 330	Continued From page 43 -There was an entry for Novolog insulin check FSBS before meals; SSI FSBS 176-210 administer 1 units of insulin, FSBS 211-245 administer 2 units of insulin, FSBS 246-280 administer 3 units of insulin, FSBS 281-315 administer 4 units of insulin, FSBS 316-350 administer 4 units of insulin, 351-385 administer 6 units of insulin, FSBS 386-420 administer 7 units of insulin, scheduled for administration at 8:00am, 12:00pm, and 5:00pm, and FSBS over 420 call the PCP. -A FSBS of 232 was documented on 01/28/23 at 8:00am, there was an entry that Novolog was not administered on 01/28/23 at 8:00am, when 2 units of Novolog should have been administered. -A FSBS of 211 was documented on 01/29/23 at 12:00pm; Novolog was documented as not administered, when Novolog 2 units should have been administered. Review of Resident #1's February 2023 MAR revealed: -There was an entry for Novolog insulin to inject 12 units with meals at 8:00am, 12:00pm, and 5:00pm and follow the SSI parameters. -There was an entry for Novolog insulin check FSBS before meals; SSI FSBS 176-210 administer 1 units of insulin, FSBS 211-245 administer 2 units of insulin, FSBS 246-280 administer 3 units of insulin, FSBS 281-315 administer 4 units of insulin, FSBS 316-350 administer 4 units of insulin, 351-385 administer 6 units of insulin, FSBS 386-420 administer 7 units of insulin, scheduled for administration at 8:00am, 12:00pm, and 5:00pm, and FSBS over 420 call the PCP. -A FSBS of 129 was documented on 02/02/23 at 8:00am; 1 unit of Novolog was documented as administered, when Novolog should not have been administered.	C 330		

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C 330	Continued From page 44 -A FSBS of 226 was documented on 02/02/23 at 5:00pm; Novolog was not documented as administered, when Novolog 2 units should have been administered. -A FSBS of 308 was documented on 02/05/23 at 12:00pm; 8 units of Novolog was documented as administered, when Novolog 4 units should have been administered. -A FSBS of 183 was documented on 02/05/23 at 5:00pm; 4 units of Novolog was documented as administered, when Novolog 1 unit should have been administered. -A FSBS of 190 was documented 02/06/23 at 12:00pm; Novolog was not documented as administered, when Novolog 1 unit should have been administered. -A FSBS of 204 was documented 02/07/23 at 5:00pm; Novolog was not documented as administered, when Novolog 1 unit should have been administered. -A FSBS of 181 was documented 02/07/23 at 8:00pm; Novolog was not documented as administered, when Novolog 1 unit should have been administered. -A FSBS of 202 was documented 02/08/23 at 5:00pm; Novolog was not documented as administered, when Novolog 1 unit should have been administered. -A FSBS of 200 was documented 02/08/23 at 8:00pm; Novolog was not documented as administered, when Novolog 1 unit should have been administered. -A FSBS of 258 was documented on 02/09/23 at 12:00pm; 8 units of Novolog was documented as administered, when Novolog 3 units should have been administered. -A FSBS of 232 was documented on 02/09/23 at 8:00pm; 8 units of Novolog was documented as administered, when Novolog 2 units should have been administered.	C 330		

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C 330	Continued From page 45 -A FSBS of 236 was documented on 02/10/23 at 12:00pm; 8 units of Novolog was documented as administered, when Novolog 2 units should have been administered. -A FSBS of 176 was documented 02/10/23 at 5:00pm; Novolog was not documented as administered, when Novolog 1 unit should have been administered. -A FSBS of 286 was documented on 02/10/23 at 8:00pm; 8 units of Novolog was documented as administered, when Novolog 4 units should have been administered. -A FSBS of 219 was documented 02/11/23 at 12:00pm; 8 units of Novolog was documented as administered, when Novolog 2 units should have been administered. -A FSBS of 191 was documented on 02/11/23 at 12:00pm; Novolog was not documented as administered, when Novolog 1 unit should have been administered. -A FSBS of 266 was documented on 02/12/23 at 12:00pm; 8 units of Novolog was documented as administered, when Novolog 3 units should have been administered. -A FSBS of 172 was documented on 02/14/23 at 8:00pm; 8 units of Novolog was documented as administered, when no Novolog should not have been administered. -A FSBS of 234 was documented on 02/15/23 at 8:00pm; 8 units of Novolog was documented as administered, when Novolog 2 units should have been administered. -A FSBS of 238 was documented on 02/17/23 at 12:00pm; 8 units of Novolog was documented as administered, when Novolog 2 units should have been administered. -A FSBS of 149 was documented on 02/18/23 at 8:00pm; 8 units of Novolog was documented as administered, when no Novolog should not have been administered.	C 330		

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C 330	Continued From page 46 -A FSBS of 191 was documented on 02/19/23 at 5:00pm; 8 units of Novolog was documented as administered, when Novolog 1 unit should have been administered. -A FSBS of 232 was documented on 02/20/23 at 12:00pm; 8 units of Novolog was documented as administered, when Novolog 2 units should have been administered. -A FSBS of 191 was documented on 02/20/23 at 5:00pm; 8 units of Novolog was documented as administered, when Novolog 1 unit should have been administered. -A FSBS of 121 was documented on 02/21/23 at 12:00pm; 8 units of Novolog was documented as administered, when no Novolog should not have been administered. -A FSBS of 179 was documented on 02/21/23 at 5:00pm; 8 units of Novolog was documented as administered, when Novolog 1 unit should have been administered. -FSBSs ranged from 129 to 308 from 02/01/23 to 02/21/23. -A FSBS of 218 was documented on 02/24/23 at 8:00pm; 12 units of Novolog was documented as administered, when Novolog 2 units should have been administered. -A FSBS of 224 was documented on 02/25/23 at 12:00pm; 12 units of Novolog was documented as administered, when Novolog 2 units should have been administered. -A FSBS of 310 was documented on 02/26/23 at 12:00pm; 12 units of Novolog was documented as administered, when Novolog 4 units should have been administered. -A FSBS of 188 was documented on 02/27/23 at 3:00pm; 12 units of Novolog was documented as administered, when Novolog 1 unit should have been administered. -A FSBS of 371 was documented on 02/28/23 at 12:00pm; 12 units of Novolog was documented	C 330		

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as administered, when Novolog 6 units should have been administered.
-A FSBS of 271 was documented on 02/28/23 at 5:00pm; 12 units of Novolog was documented as administered, when Novolog 3 units should have been administered.
-FSBS's ranged from 127 to 371 from 02/23/23 to 02/28/23.

Review of Resident #1's March 2023 (MAR) revealed:
-Do not give Novolog if FSBS is less than 150.
-FSBS less than 70 or greater than 300 call the PCP.
-A FSBS of 332 was documented 03/01/23 at 12:00pm; Novolog was not documented as administered, when Novolog 4 units should have been administered.
-A FSBS of 332 was documented 03/01/23 at 5:00pm; Novolog was not documented as administered, when Novolog 4 units should have been administered.
-A FSBS of 335 was documented 03/04/23 at 5:00pm; Novolog was not documented as administered, when Novolog 4 units should have been administered.
-A FSBS of 191 was documented 03/06/23 at 12:00pm; Novolog was not documented as administered, when Novolog 1 unit should have been administered.
-A FSBS of 418 was documented 03/07/23 at 12:00pm; Novolog was not documented as administered, when Novolog 7 units should have been administered.
-A FSBS of 210 was documented on 03/09/23 at 9:00am; 12 units of Novolog was documented as administered, when Novolog 1 unit should have been administered.
-A FSBS of 259 was documented on 03/10/23 at 8:45am; 12 units of Novolog was documented as

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administered, when Novolog 3 units should have been administered.
-A FSBS of 459 was documented on 03/10/23 at 5:00pm; 12 units of Novolog was documented as administered, when no Novolog should not have been administered.
-A FSBS of 259 was documented on 03/11/23 at 9:00am; 12 units of Novolog was documented as administered, when Novolog 3 units should have been administered.
-A FSBS of 187 was documented on 03/14/23 at 9:30am; 12 units of Novolog was documented as administered, when Novolog 1 unit should have been administered.
-A FSBS of 390 was documented on 03/15/23 at 8:30am; 12 units of Novolog was documented as administered, when Novolog 1 unit should have been administered.
-A FSBS of 232 was documented on 03/15/23 at 5:00pm; 4 units of Novolog was documented as administered, when Novolog 2 units should have been administered.
-A FSBS of 254 was documented on 03/18/23 at 5:00pm; 6 units of Novolog was documented as administered, when Novolog 3 units should have been administered.
-A FSBS of 196 was documented on 03/20/23 at 8:30am; 12 units of Novolog was documented as administered, when Novolog 1 unit should have been administered.
-A FSBS of 117 was documented on 03/23/23 at 12:00pm; 8 units of Novolog was documented as administered, when no Novolog should not have been administered.
-A FSBS of 86 was documented on 03/24/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should have been administered.
-A FSBS of 119 was documented on 03/25/23 at 8:00am; 8 units of Novolog was documented as

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administered, when no Novolog should not have been administered.
-A FSBS of 118 was documented on 03/26/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered.
-A FSBS of 100 was documented on 03/27/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered.
-A FSBS of 108 was documented on 03/28/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered.
-A FSBS of 85 was documented on 03/29/23 at 8:30am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered.
-A FSBS of 76 was documented on 03/31/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered.
-FSBS's ranged from 76 to 459 from 03/01/23 to 03/31/23.

Review of Resident #1's April 2023 (MAR) revealed:
-Do not give Novolog if FSBS is less than 150.
-FSBS less than 70 or greater than 300 call the PCP.
-There was an entry for Novolog to inject 12 units with meals and follow the SSI parameters.
-A FSBS of 560 was documented 04/01/23 at 2:30pm; 10 units of Novolog was documented as administered, when no Novolog should have been administered.
-A FSBS of 124 was documented on 04/03/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered.

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C 330	Continued From page 50 -A FSBS of 82 was documented on 04/04/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered. -A FSBS of 143 was documented on 04/05/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered. -A FSBS of 117 was documented on 04/03/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered. -A FSBS of 62 was documented on 04/07/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered. -A FSBS of 107 was documented on 04/08/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered. -A FSBS of 124 was documented on 04/09/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered. -A FSBS of 120 was documented on 04/10/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered. -A FSBS of 149 was documented on 04/11/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered. -A FSBS of 149 was documented on 04/12/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered. -A FSBS of 101 was documented on 04/13/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered.	C 330		

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-A FSBS of 133 was documented on 04/13/23 at 12:00pm; 8 units of Novolog was documented as administered, when no Novolog should not have been administered.
-A FSBS of 121 was documented on 04/15/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered.
-A FSBS of 110 was documented on 04/16/23 at 8:00am; 8 units of Novolog was documented as administered, when no Novolog should not have been administered.
-FSBS's ranged from 62 to 560 from 04/01/23 to 04/16/23.

Interview with the medication aide (MA)/Administrator on 04/18/23 at 3:24pm revealed:
-She talked with the resident's primary care provider (PCP) at his first appointment on 02/22/23.
-She explained to the PCP that she had a difficult time understanding his Novolog and SSI.

Refer to interview with the MA/Administrator on 04/19/23 at 12:32pm.

Refer to telephone interview with the facility's nurse consultant on 04/19/23 at 11:51am.

Refer to telephone interview with Resident #1's PCP on 04/20/23 at 4:03pm.

4. Review of a physician's order revealed there was an order for Basaglar (a long-acting insulin used to treat high blood sugars) 110 units/ml kwik pen, inject 35 units at bedtime 8:00pm.

Review of Resident #1's January 2023 medication administration record (MAR) revealed:

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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
C 330	Continued From page 52 -There was an was an entry for Basaglar 110 units/ml, inject 35 unit, scheduled at bedtime 8:00pm. -On the front of the MAR on 01/26/23, there were initials in the box at 8:00pm; on the back of the MAR, it was documented no insulin was administered. -On the front of the MAR on 01/27/23, there were initials in the box at 8:00pm; on the back of the MAR, it was documented no insulin was administered. -On the front of the MAR on 01/28/23, there were initials in the box at 8:00pm; on the back of the MAR, it was documented no insulin was administered. -On the front of the MAR on 01/29/23, there were initials in the box at 8:00pm; on the back of the MAR, it was documented no insulin was administered. -On the front of the MAR on 01/30/23, there were initials in the box at 8:00pm; on the back of the MAR, it was documented no insulin was administered. -On the front of the MAR on 01/31/23, there were no initials in the box with no designated time; on the back of the MAR, it was documented no insulin was administered. Review of Resident #1's February 2023 MAR revealed: -There was an was an entry for Basaglar 110 units/ml, inject 35 unit, scheduled at bedtime 8:00pm. -On the front of the MAR on 02/01/23, there were initials in the box at 8:00pm; on the back of the MAR, it was documented no insulin was administered. -On the front of the MAR on 02/02/23, there were initials in the box at 8:00am; on the back of the MAR, it was documented no insulin was	C 330		

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C 330	Continued From page 53 administered. -On the front of the MAR on 02/06/23, there were initials in the box at 8:00am and 8:00pm; on the back of the MAR it was documented no insulin was administered at 8:00am or 8:00pm. -On the front of the MAR on 02/07/23, there were initials in the box at 8:00am; on the back of the MAR, it was documented 2 units of insulin was administered. -On the front of the MAR on 02/08/23, there were initials in the box at 8:00am; on the back of the MAR, it was documented no insulin was administered. -On the front of the MAR on 02/09/23, there were initials in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 8:41am. -On the front of the MAR on 02/10/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented no insulin was administered. -On the front of the MAR on 02/11/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered 8:30am. -On the front of the MAR on 02/12/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 8:30am. -On the front of the MAR on 02/13/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 10:00am. -On the front of the MAR on 02/14/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 8:30am. -On the front of the MAR on 02/15/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was	C 330		

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C 330	Continued From page 54	C 330		

administered at 9:00am.
-On the front of the MAR on 02/16/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 12:30pm.
-On the front of the MAR on 02/17/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 8:30am.
-On the front of the MAR on 02/18/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 12:00pm.
-On the front of the MAR on 02/19/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 11:39am.
-On the front of the MAR on 02/20/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 8:30am.
-On the front of the MAR on 02/21/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 8:30am.
-On the front of the MAR on 02/22/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 8:00am.
-On the front of the MAR on 02/23/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 8:00am.
-On the front of the MAR on 02/24/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 8:30am.
-On the front of the MAR on 02/25/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was

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C 330	Continued From page 55	C 330		

administered at 8:30am.
-On the front of the MAR on 02/26/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 8:30am.
-On the front of the MAR on 02/27/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 8:30am.
-On the front of the MAR on 02/28/23, there was an initial in the box at 8:00am; on the back of the MAR, it was documented 35 units of insulin was administered at 8:30am.

Interview with the medication aide (MA)/Administrator on 04/19/23 at 8:45am revealed:
-The first time she administered Basaglar 35 units was 01/30/23.
-She did not realize that she had administered the Basaglar at the wrong time, she should have administered the medication at bedtime, 8:00pm.
-She began administering the resident's Basaglar at bedtime, 8:00pm on 03/01/23.
-She had training from a nurse consultant and an account executive from the facility's contracted pharmacy on how to document on the MARs but still had problems with making sure she documented the administration of medications correctly on the MAR.

Interview with Resident #1's PCP on 04/20/23 at 4:03pm revealed:
-Resident #1 needed Novolog and Basaglar to help control his type 2 diabetes.
-Resident #1 was at risk of long term health problems such as congestive heart failure, diabetic neuropathy and long term damage to his kidneys when his blood sugar was too high.
-The resident was placed at an increased risk of

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C 330	Continued From page 56	C 330		

becoming nonresponsive or dying if his sugar became too low and his insulin was not administered as ordered.

5. Review of Resident #1's current FL-2 dated 01/23/23 revealed there was an order for Vimpat 200mg once a day (a medication to prevent seizures).

Review of Resident #1's January 2023 medication administration record (MAR) revealed:
-There was an entry for Vimpat 200mg once a day at 8:00am.
-Vimpat was documented as administered at 8:00am and 8:00pm on 01/28/23.

Review of a physician order dated 02/22/23 revealed there was an order to administer Vimpat 200mg twice a day at 8:00am and 8:00pm.

Review of Resident #1's March 2023 MAR revealed:
-There was an entry for Vimpat 200mg twice a day at 8:00am and 8:00pm.
-There was an entry on 03/31/23 that one Vimpat 200mg was administered at 8:00am; there was no documentation that a second Vimpat 200mg was administered at 8:00pm.

Review of Resident #1's control substance log (CSL) on 04/19/23 at 2:20pm revealed:
-There was an entry on page one that Vimpat 200mg was administered on 01/26/23 at 2:00pm with a pill count of 14.
-There was an entry that Vimpat 200mg was administered on 02/04/23 at 8:30am with a pill count of 13.
-There was an entry that Vimpat 200mg was administered on 02/05/23 at 8:30am with a pill count of 12.

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C 330	Continued From page 57 -There was an entry on page 2 that Vimpat 200mg was administered on 01/27/23 at 9:00am with a pill count of 8. -There was an entry that Vimpat 200mg was administered on 01/28/23 with no time documented with a pill count of 7. -There was an entry that Vimpat 200mg was administered on 01/29/23 at 9:00am with a pill count of 6. -There was an entry that Vimpat 200mg was administered on 01/30/23 at 8:30am with a pill count of 5. -There was second entry that Vimpat 200mg was administered on 01/30/23 at 8:30am with a pill count of 4. -There was an entry that Vimpat 200mg was administered on 02/01/23 at 8:00am with a pill count of 3. -There was an entry that Vimpat 200mg was administered on 02/02/23 at 8:00am with a pill count of 2. -There was an entry that Vimpat 200mg was administered on 02/03/23 at 8:30am with a pill count of 1. Interview with the medication aide (MA)/Administrator on 04/19/23 at 12:32pm revealed: -She did not realize that she had administered Resident #1 a second dose of Vimpat 200mg on 01/28/23. -She was responsible for following the PCP orders. -When she had a question about a medication, she would call her nurse consultant or the PCP. -She had also received training from the facility's contract pharmacy account executive on the importance of following PCP orders and ensuring correct documentation of medications administered.	C 330		

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C 330	Continued From page 58 Interview with a pharmacist at the facility's contracted pharmacy on 04/19/23 at 10:29am revealed: -The pharmacy dispensed a quantity of 14 Vimpat 200mg tablets to the facility on 01/25/23 for a 14 day supply. -The pharmacy received an order from the PCP on 02/17/23 to increase the Vimpat 200mg once a day to twice a day at 8:00am and 8:00pm. -The pharmacy dispensed a quantity of 60 Vimpat 200mg tablets to the facility on 02/17/23. -The pharmacy dispensed a quantity of 60 Vimpat 200mg tablets to the facility on 03/20/23. -The pharmacy dispensed a quantity of 60 Vimpat 200mg tablets to the facility on 04/19/23. Interview with the facility's nurse consultant on 04/19/23 at 11:51am revealed: -She usually visited the facility a few times a week but had not been in 2 to 3 weeks. -She had provided education to the MA/Administrator on how to follow PCP orders and administer all medications per the PCP orders. -The MA/Administrator had been instructed to call her if she had any questions. -She had provided education on the importance of proper documentation on the MAR to ensure the resident received his medications as ordered. -The MA/Administrator should not have administered an additional dose of Vimpat 200mg without an order from the PCP. Interview with Resident #1's PCP on 04/20/23 at 4:03pm revealed: -He expected the MA/Administrator to follow PCP orders and to contact him if she had any questions or needed clarification on an order. -Missing a second dose of Vimpat 200mg as	C 330		

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C 330	Continued From page 59 ordered placed the resident at an increased risk of break through seizures which increased the resident's risk of falls and an injury. _____ The facility failed to follow medication orders and administered incorrect doses of insulin to a resident which caused high blood sugar which could cause damage to the resident's heart, pancreas, and liver, caused low blood sugar which placed the resident at risk of becoming nonresponsive and possibly lead to death, and failed to administer a seizure medication that placed the resident at an increased risk of break through seizures. The failure resulted in serious physical harm and serious neglect to the resident and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/18/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 20, 2023.	C 330		
C 346	10A NCAC 13G .1004(n) Medication Administration 10A NCAC 13G .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure medications were administered in	C 346		

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accordance with infection control measures to prevent the development and transmission of disease or infection, prevent cross-contamination, and provide a safe and sanitary environment for staff and residents when administering 1 of 1 resident (#1) medication.

The findings are:

Review of an undated medication administration facility policy revealed the facility shall ensure that medications are administered in accordance with infection control measures to help prevent the development and transmission of disease or infection, prevent cross-contamination, and provide a safe and sanitary environment for staff and residents.

Review of Resident #1's current FL-2 dated 01/23/23 revealed:
-Diagnoses included diabetes, hyperglycemia (high blood sugar), cerebral infarction (stroke) and seizures.
-There was an order for Protonix 40mg daily (Protonix is a medication used to treat gastroesophageal reflux disease).
-There was an order for Tylenol 325mg (Tylenol is a medication used to treat pain and fever).
-There was an order for Vimpat 200mg (Vimpat is a medication used to treat seizures).
-There was an order for Aspirin 81mg chewable tablet.
-There was an order for Colace 100mg (Colace is a medication used to treat constipation).
-There was an order for Tamsulosin HCL 0.4mg (Tamsulosin is a medication used to treat an enlarged prostate).
-There was an order for Lisinopril 5mg (Lisinopril is a medication used to treat high blood pressure).

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C 346	Continued From page 61 Observation of the medication aide (MA)/Administrator on 04/19/23 at 8:15am revealed: -The MA/Administrator had pills in a clear plastic cup at the kitchen table when Resident #1 was eating breakfast. -The MA/Administrator did not wear gloves. -The MA/Administrator reached into the plastic cup with her hands and placed two pills in the resident's hand. Interview with the MA/Administrator on 04/19/23 at 8:30am revealed: -She was supposed to wear gloves when she administered medications. -She had washed her hands prior to preparing the resident medications but should have worn gloves. -The resident was capable of taking the medication from the plastic cup and she did not have to hand him the medication. -She could have contaminated the resident's medications by not wearing gloves to administer his medication. -She should have worn gloves to prevent any type of infection to the resident. -She had completed an online course on infection control and just forgot to wear gloves when administering the resident's medication. Telephone interview with Resident #1's primary care provider (PCP) on 04/20/23 at 4:03pm revealed: -He expected staff to administer medications in accordance with infection control principles including not handling medications without gloves. -He expected staff to wash their hands before and after medication administration to eliminate	C 346		

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C 346	Continued From page 62 cross contamination and risk for spread of disease. -He expected the MA/Administrator to wear gloves when administering medication to Resident #1 to minimize the risk of infection. -The MA/Administrator placed the resident at an increased risk of a staphylococcus infection (an infection caused by bacteria commonly found on the skin) or fungal infection. -Resident #1 was at an increased risk of infections because he had a weakened immune system due to his diabetes.	C 346		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure controlled substance records for 1 of 1 resident (#1) were accurately reconciled with the administration of a controlled substance used for seizures. The findings are: Review of Resident #1's current FL-2 dated 01/23/23 revealed diagnoses included diabetes, hyperglycemia (high blood sugar), cerebral infarction (stroke) and seizures and an order for Vimpat 200mg once a day (a medication to prevent seizures).	C 367		

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C 367	Continued From page 63 Review of Resident #1's January 2023 medication administration record (MAR) revealed: -There was an entry for Vimpat 200mg once a day at 8:00am. -There was no documentation that Vimpat 200mg was administered on 01/28/23. -There was documentation that Vimpat 200mg was administered on 01/30/23 at 8:00am. -There was documentation that Vimpat 200mg was administered on 01/31/23 at 8:00am. Review of a physician order dated 02/22/23 revealed there was an order to administer Vimpat 200mg twice a day at 8:00am and 8:00pm. Review of Resident #1's February 2023 MAR revealed: -There was an entry for Vimpat 200mg twice a day at 8:00am and 8:00pm. -There was documentation that Vimpat 200mg was administered on 02/23/23 at 8:00am and 8:00pm. Review of Resident #1's March 2023 MAR revealed: -There was an entry for Vimpat 200mg twice a day at 8:00am and 8:00pm. -There was documentation that Vimpat 200mg was administered on 03/28/23 at 8:00am and 8:00pm. -There was documentation that Vimpat 200mg was administered on 03/29/23 at 8:00am and 8:00pm. Review of Resident #1's control substance log (CSL) on 04/19/23 at 2:20pm revealed: -There was an entry that Vimpat 200mg was administered on 01/28/23 at 8:00am with the medication aide (MA)/Administrator's initials; in a	C 367		

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box below the 8:00am entry the MA/Administrator initialed a second administration of Vimpat without a time.
-There was an entry that Vimpat 200mg was administered on 01/30/23 at 8:30am and a second entry that Vimpat 200mg was administered on 01/30/23 at 8:30am.
-There was no documentation that Vimpat 200mg was administered on 02/23/23; the entry was left blank.
-There was an entry that Vimpat 200mg was administered on 03/28/23 at 8:00am and 8:00pm and a second entry that Vimpat 200mg was administered a second time on 03/28/23 at 8:00am and 8:00pm.

Interview with the facility's nurse consultant on 04/19/23 at 11:51am revealed:
-She usually visited the facility a few times a week but had not been in 2 to 3 weeks.
-She had provided education to the MA/Administrator on how to follow PCP orders and administer all medications per the PCP orders.
-The MA/Administrator had been instructed to call her if she had any questions.
-She had provided education on the importance of proper documentation on the MAR to ensure the resident received his medications as ordered.

Interview with the facility's contracted pharmacy on 04/19/23 at 10:29am revealed:
-The pharmacy provided a monthly CSL for the facility.
-The pharmacy dispensed a quantity of 14 Vimpat 200mg tablets to the facility on 01/25/23 for a 14 day supply.
-The pharmacy received an order from the PCP on 02/17/23 to increase the Vimpat 200mg once a day to twice a day at 8:00am and 8:00pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-098-03	A. BUILDING: _____ B. WING _____	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANDS THAT CARES	5209 ACRES ROAD ELM CITY, NC 27822

(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 367	Continued From page 65 -The pharmacy dispensed a quantity of 60 Vimpat 200mg tablets to the facility on 02/17/23. -The pharmacy dispensed a quantity of 60 Vimpat 200mg tablets to the facility on 03/20/23. -The pharmacy dispensed a quantity of 60 Vimpat 200mg tablets to the facility on 04/19/23. Interview with the MA/Administrator on 04/19/23 at 12:32pm revealed: -The pharmacy delivery would arrive later today for Resident #1's Vimpat. -She had a difficult time understanding how to document on the CSL when the resident was first admitted. -She made errors with the dates on different pages of the CSL. -She was responsible for following the PCP orders. -When she had a question about a medication, she would call her nurse consultant or the PCP. -She had also received training from the facility's contract pharmacy account executive on the importance of following PCP orders and ensuring correct documentation of medications administered. Interview with the PCP on 04/20/23 at 4:03pm revealed: -He expected the MA/Administrator to follow PCP orders and to contact him if she had any questions or needed clarification on an order. -Missing a second dose of Vimpat 200mg as ordered placed the resident at an increased risk of break through seizures which increased the resident's risk of falls and an injury.	C 367		