STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 05/24/23 to 05/25/23.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, record reviews and interviews, the facility failed to administer medication as ordered for 1 of 3 sampled residents (#1) who had orders for as-needed insulin, sliding scale insulin, short-acting insulin, long-acting insulin, an anti-emetic medication, and medication for nerve pain. The findings are: Review of Resident #1's current FL2 dated 05/03/23 revealed diagnoses included diabetes mellitus, transient ischemic stroke, hypertension, and major depressive disorder. Review of Resident #1's Progress Notes revealed:	D 358		

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D 358	Continued From page 1 -On 05/04/23 at 9:57am, Resident #1 was sent to the Emergency Room (ER) yesterday, 05/03/23, due to complaints of elevated fingerstick blood sugar (FSBS) and nausea. -On 05/04/23 at 4:05pm, Resident #1 returned to the facility from the ER. -On 05/06/23 at 8:12am, Resident #1 was sent via ambulance to the ER for evaluation due to elevated FSBS of 542. -On 05/06/23 at 7:24pm, Resident #1 returned to the facility from the ER. -On 05/06/23 at 7:53pm, Resident #1 was found unresponsive in the facility's doorway, his blood pressure was 112/62, heart rate was 48 beats per minute, temperature was 97.4, and FSBS was 277; 911 was called and Resident #1 was sent to the ER via ambulance. -On 05/11/23 at 8:10pm, Resident #1 was discharged from the hospital and returned to the facility with new insulin orders. -On 05/11/23 at 8:11pm, during the bedtime medication pass, Resident #1's FSBS was 512 and 911 was called; Resident #1 was sent to the ER via ambulance. -On 05/12/23 at 8:25pm, Resident #1 returned to the facility. -On 05/12/23 at 8:25pm, Resident #1's FSBS at bedtime was 560, 911 was called, but Resident #1 refused to go to the ER with the paramedics. -On 05/13/23 at 7:39am, Resident #1's FSBS was 500, but he refused to go to the ER. -On 05/13/23 at 9:14pm, Resident #1's FSBS was 485, 911 was called and Resident #1 was sent via ambulance to the ER. -On 05/14/23 at 4:45pm, Resident #1's FSBS was 478 and Resident #1 refused to take insulin or go to the ER. Review of Resident's #1's hospital discharge summary dated 05/04/23 revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

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D 358	Continued From page 2	D 358		

-Resident #1 had a diagnosis of acidosis (a build-up of acid in the bloodstream often caused by unmanaged blood glucose levels).
-New discharge orders included Novolog insulin, inject 5 units subcutaneously 4 times daily as needed, and per sliding scale insulin (SSI) for FSBS: 70-130 = 0 units, 131-180 = 2 units, 181-240 = 4 units, 241-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, greater than 400 = 12 units and repeat FSBS in 2 hours and notify PCP.

Review of Resident #1's hospital discharge summary dated 05/06/23 revealed:
-Resident #1 had been admitted to the hospital due to diagnoses of hyperglycemia (high blood sugar levels) and hypertension (high blood pressure).
-He was discharged from the hospital with the same Novolog SSI order from 05/04/23.
-There were no documented FSBS values listed on the discharge summary.

Review of Resident #1's hospital discharge summary dated 05/11/23 revealed:
-Resident #1 was admitted to the hospital from 05/06/23 through 05/11/23 due to diagnoses of syncope and collapse, orthostatic hypotension, elevated troponin, anemia and hyperglycemia.
-Resident #1's FSBS upon arrival to the hospital was 277 and his blood pressure was 91/57.
-There was documentation that Resident #1 experienced both high and low FSBS values while hospitalized.
-Resident #1's hemoglobin A1C was 6.9% which indicated per the hospital physician that he had fluctuations in blood sugars over the previous three months (normal level is below 5.7%, a level of 6.5% or higher indicates diabetes).
-Resident #1 was discharged with a new order for a blood pressure medication, a long-acting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

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D 358	Continued From page 3	D 358		

insulin, and an adjusted Novolog SSI.

Review of Resident #1's hospital discharge summary dated 05/11/23 revealed:
-Resident #1 presented to the ER with a diagnosis of elevated blood sugar with no symptoms.
-He was diagnosed with hyperglycemia due to diabetes mellitus.
-There were no documented FSBS values.

Review of Resident #1's hospital discharge summary dated 05/13/23 revealed:
-Resident #1 had an admission diagnosis of elevated blood sugar with no symptoms.
-He was diagnosed with hyperglycemia.
-There were no documented FSBS values.

a. Review of Resident #1's current FL2 dated 05/03/23 revealed:
-There was an order for Novolog insulin (a rapid-acting insulin to treat high blood sugar levels), inject 5 units subcutaneously four times daily as needed for fingerstick blood sugar (FSBS) greater than 450.
-There was an order for FSBS checks once daily and as needed.

Review of Resident #1's May 2023 eMAR from 05/01/23 through 05/24/23 revealed:
-There was an entry for Novolog insulin, inject 5 units four times daily as needed with a start date of 05/05/23.
-There was documentation Novolog 5 units was administered on 05/06/23 for a FSBS value of 542.
-On 05/12/23 at 8:00pm, the FSBS was 556 and 5 units of insulin were not documented as administered.
-On 05/13/23 at 8:00am, the FSBS was 500 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

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SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

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D 358	Continued From page 4	D 358		

5 units of insulin were not documented as administered.
-On 05/13/23 at 8:00pm, the FSBS was 467 and 5 units of insulin were not documented as administered.
-On 05/14/23 at 4:30pm, the FSBS was 478 and 5 units of insulin were not documented as administered.
-On 05/14/23 at 8:00pm, the FSBS was 468 and 5 units of insulin were not documented as administered.
-On 05/15/23 at 8:00pm, the FSBS was 454 and 5 units of insulin were not documented as administered.
-Resident #1's FSBS values from 05/01/23 through 05/24/23 ranged from 88 to 542.

Observation of medication on hand for Resident #1 on 05/24/23 at 2:00pm revealed there was 1 Novolog insulin pen with a dispensed date of 05/14/23 and 75 units of insulin remaining in the pen.

Interview with Resident #1 on 05/24/23 at 1:00pm revealed:
-He had gone to the hospital several times in May 2023 for FSBS in the 400's and 500's.
-He was not sure what had caused his FSBS to go so high.
-He did not usually feel symptomatic when his FSBS values were high.
-There was one medication aide (MA) who sometimes administered his as-needed (5 units) Novolog insulin when his FSBS values were high, but he could not remember which days.
-There were times in the last month that the MA checked his FSBS, administered the as-needed insulin, then rechecked it and his FSBS was lower.
-He thought his trips to the Emergency Room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

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D 358	Continued From page 5	D 358		

(ER) could have been prevented if he had received his as-needed insulin as ordered.

Interview with a MA on 05/24/23 at 1:30pm revealed:
-He was the live-in staff of the facility and worked all day almost every day as the MA.
-At the beginning of May 2023, Resident #1's only diabetic medications were his as-needed Novolog insulin, and an oral antidiabetic medication which he had received twice daily as ordered.
-He was not able to administer Resident #1 his as-needed Novolog insulin on the days when his FSBS was over 450 because he did not have any available to administer.
-On 05/03/23, he could not remember if he checked or rechecked Resident #1's FSBS, but he remembered he sent him to the ER because he had nausea and was vomiting.
-When Resident #1 returned from the ER on 05/04/23 he requested a refill for Resident #1's Novolog insulin, but he could not remember if he had requested a Novolog insulin refill prior to Resident #1 going to the ER.
-He documented administering Resident #1's as-needed Novolog insulin on 05/06/23 but thought he had used up the remainder of his previous Novolog insulin pen and had to order more.
-He got Resident #1's current Novolog insulin pen from the back-up pharmacy, and he was still waiting on the VA to mail Resident #1's Novolog insulin pen.
-If he checked Resident #1's FSBS, or rechecked his FSBS after administering insulin, he always documented it on the eMAR.
-He sent Resident #1 to the ER each time his FSBS was over 450 for the safety of Resident #1, because he did not have as-needed Novolog insulin to administer to him because the

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	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

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SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

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D 358	Continued From page 6	D 358		

pharmacy had not delivered it yet.
-Resident #1 was never symptomatic when he sent him to the ER.
-When Resident #1 went to the ER on the evening of 05/06/23, his FSBS was only 277 so he thought something else had caused his episode of unresponsiveness.
-The Office Manager (OM) audited the eMARs monthly, but had not said anything to him about Resident #1's FSBS values or why he was not administering Resident #1 his as-needed insulin.
-He did not document his phone calls to the VA pharmacy to request a refill of Resident #1's Novolog insulin pen.

Telephone interview with a technician from the VA pharmacy on 05/25/23 at 8:45am revealed:
-The pharmacy last dispensed Novolog insulin to the facility for Resident #1 on 01/31/23 for a quantity of 5 insulin pens which was a 90-day supply.
-When they dispensed Novolog for Resident #1 on 01/31/23, his order was for 3 units three times daily with meals and 5 units four times daily as needed for FSBS greater than 450.
-Resident #1 still had refills available for Novolog insulin and it did not look like the facility had sent them a refill request.

Interview with the Resident Care Director (RCD) on 05/25/23 at 10:20am revealed:
-She was aware that Resident #1 was waiting for the delivery for some of his medications from the VA pharmacy but was not aware he did not have his as-needed Novolog insulin available.
-The VA pharmacy told her that Resident #1's medications, including his Novolog insulin, would be shipped to the facility as soon as possible, but the insulin had not yet arrived.
-She could not remember the exact date of her

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	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

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SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

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D 358	Continued From page 7	D 358		

last call to the VA pharmacy for Resident #1.
-Resident #1 had not experienced any symptoms on the days he was sent to the ER for high blood sugar except 05/06/23 but that was due to his blood pressure rather than his blood sugar.

Telephone interview with a representative from the facility's contracted pharmacy on 05/25/23 at 10:50am revealed:
-Resident #1 had a current order on file for Novolog insulin, inject 5 units four times daily as needed for FSBS greater than 450, recheck in 1 hour and if not lower notify the PCP.
-They had no history of dispensing Novolog insulin to the facility for Resident #1 but could see that the back-up pharmacy had dispensed 1 Novolog insulin pen for him on 05/14/23 at 11:00am.

Interview with the OM on 05/25/23 at 11:43am revealed:
-She was not aware that Resident #1 did not have a Novolog insulin pen available for as-needed administration on the days his FSBS was over 450 and he was sent to the ER.
-When Resident #1's FSBS was 450 or higher, he never complained of being symptomatic.
-Whenever Resident #1's FSBS was over 450, the MA just called 911 and sent him to the ER.

Interview with the Administrator on 05/25/23 at 2:15pm revealed:
-She was not aware that Resident #1 did not have his as-needed Novolog insulin available for administration on the days he was sent to the ER for FSBS over 450.
-She had picked Resident #1 up from the ER on 05/06/23 and the MA told her that he had all of Resident #1's medications available for administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

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D 358	Continued From page 8	D 358		

-The MA notified the facility's PCP about Resident #1's FSBS and ER trips weekly when she was at the facility.

Attempted telephone interview with the facility's PCP on 05/25/23 at 10:00am was unsuccessful.

Attempted telephone interview with Resident #1's VA PCP on 05/25/23 at 9:15am was unsuccessful.

Based on record reviews and interviews, the facility failed to administer Resident #1's as needed insulin for FSBS greater than 450 as ordered by the physician.

Refer to interview with Resident #1 on 05/24/23 at 1:00pm.

Refer to interview with the MA on 05/24/23 at 1:30pm.

Refer to telephone interview with a technician from the VA pharmacy on 05/25/23 at 8:45am.

Refer to interview with the RCD on 05/25/23 at 10:20am.

Refer to interview with the OM on 05/25/23 at 11:43am.

Refer to interview with the Administrator on 05/25/23 at 2:15pm.

b. Review of Resident #1's current FL2 dated 05/03/23 revealed an order to check fingerstick blood sugar (FSBS) once daily and as needed.

Review of Resident #1's Emergency Room (ER) physician's order dated 05/04/23 revealed an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 9	D 358		

order for Novolog (a rapid-acting insulin used to treat high blood sugar levels) sliding scale insulin (SSI) as follows for FSBS: 70-130 = 0 units, 131-180 = 2 units, 181-240 = 4 units, 241-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, greater than 400 = 12 units and repeat FSBS in 2 hours and notify primary care provider (PCP).

Review of Resident #1's hospital discharge physician's order dated 05/11/23 revealed an order for Novolog SSI as follows for FSBS: 70-150 = 0, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400 = 10 units and repeat FSBS in 2 hours and notify PCP.

Review of Resident #1's PCP's order dated 05/17/23 revealed an order to discontinue the Novolog SSI ordered from the hospital on 05/11/23.

Review of Resident #1's May 2023 electronic medication administration record (eMAR) from 05/01/23 through 05/24/23 revealed:
-There was an entry to check FSBS once daily scheduled at 8:00am.
-There was documentation FSBS was checked daily at 8:00am from 05/01/23 through 05/24/23 except on 05/04/23, from 05/07/23 through 05/12/23, and on 05/15/23 when Resident #1 was documented as being out of the facility.
-Resident #1's FSBS values from 05/01/23 through 05/24/23 ranged from 88 to 542.
-From 05/05/23 to 05/11/23, there was an entry for Novolog SSI for FSBS: 70-130 = 0 units, 131-180 = 2 units, 181-240 = 4 units, 241-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, greater than 400 = 12 units and repeat FSBS in 2 hours and notify PCP scheduled at 8:00am.
-There was documentation Resident #1's FSBS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 10	D 358		

on 05/06/23 was 542, but no insulin was administered due to resident refusing.
-There were no documented FSBS checks or insulin administration from 05/07/23 through 05/11/23 due to resident out of facility.
-From 05/11/23 to 05/24/23, there was an entry for Novolog SSI as follows for FSBS: 70-150 = 0, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400 = 10 units and repeat FSBS in 2 hours and notify PCP, scheduled at 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was documentation Novolog SSI was not administered at 8:00pm on 05/12/23 when Resident #1's FSBS was 556 due to "physically unable to take."
-There was documentation Novolog SSI was not administered at 7:30am on 05/13/23 for a FSBS of 500 due to medication out of stock.
-There was documentation Novolog SSI was not administered at 4:30pm on 05/14/23 when Resident #1's FSBS was 478 due to withheld per physician's orders.
-There was documentation Novolog SSI was not administered at 7:30am on 05/16/23 due to withheld per physician's orders but no FSBS value was documented.
-There was documentation Resident #1's FSBS at 4:30pm on 05/13/23 was 421 and 10 units Novolog SSI were administered, but there was no documentation FSBS was repeated in 2 hours.
-There was documentation Resident #1's FSBS at 8:00pm on 05/13/23 was 467 and 10 units Novolog SSI were administered, but there was no documentation FSBS was repeated in 2 hours.
-There was documentation Resident #1's FSBS at 8:00pm on 05/15/23 was 454 and 10 units Novolog SSI were administered, but there was no documentation FSBS was repeated in 2 hours.
-There was no order discontinue date entered on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 11	D 358		

05/17/23 per PCP's order, and Novolog SSI was documented as administered four times daily from 05/18/23 through 7:30am on 05/24/23 with examples as follows:
-On 05/18/23 at 7:30am, FSBS was 268 and 4 units of Novolog SSI were administered.
-On 05/20/23 at 11:30am, FSBS was 300 and 4 units of Novolog SSI were administered.
-On 05/22/23 at 4:30pm, FSBS was 322 and 6 units of Novolog SSI were administered.
-On 05/23/23 at 8:00pm, FSBS was 371 and 8 units of Novolog SSI were administered.
-FSBS values from 05/17/23 when the Novolog SSI order was discontinued through 05/24/23 ranged from 176 to 373.

Review of Resident #1's physician orders revealed there were no orders to hold the Novolog SSI on 05/14/23 and 05/16/23.

Observation of medication on hand for Resident #1 on 05/24/23 at 2:00pm revealed there was 1 Novolog insulin pen with a dispensed date of 05/14/23 and 75 units of insulin remaining in the pen.

Interview with Resident #1 on 05/24/23 at 1:00pm revealed:
-He had gone to the hospital several times in May 2023 for FSBS in the 400's and 500's.
-He did not refuse to take insulin any of the days he was sent to the ER for high FSBS values.

Interview with the MA on 05/24/23 at 1:30pm revealed:
-He was the live-in staff of the facility and worked all day almost every day.
-When Resident #1 returned from the ER on 05/04/23, and he had a new order for scheduled SSI and did not have Novolog insulin on hand in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 12	D 358		

the facility to administer to Resident #1.
-He got Resident #1's current Novolog insulin from the back-up pharmacy on 05/14/23 and he was still waiting on the VA pharmacy to mail Resident #1's Novolog insulin supply to the facility.
-If he checked Resident #1's FSBS, or rechecked his FSBS after administering insulin, he always documented it on the eMAR.
-He sent Resident #1 to the ER on 05/06/23 when his FSBS was 542 for the safety of Resident #1, because he did not have Novolog insulin to administer to Resident #1.
-When Resident #1 went to the ER on the evening of 05/06/23, his FSBS was only 277 so he thought something else had caused his episode of unresponsiveness.
-On 05/11/23, he checked Resident #1's FSBS at bedtime and the FSBS value was 512; he did not administer SSI because he did not yet have the Novolog on hand from the pharmacy, so he called 911 for Resident's #1's safety.
-On 05/12/23, he checked Resident #1's FSBS at bedtime and the FSBS value was 560; he did not administer SSI because he did not yet have the Novolog on hand from the pharmacy, so he called 911 for Resident's #1's safety, but he refused to go to the ER.
-On 05/13/23, he checked Resident #1's FSBS at 8:00am and the FSBS value was 500; he did not administer SSI because he did not yet have the Novolog on hand from the pharmacy and Resident #1 refused to go to the hospital, so he tried to contact the Administrator four times without a response.
-On 05/13/23, he checked Resident #1's FSBS at bedtime and the FSBS value was 485; he did not administer SSI because he did not yet have the Novolog on hand from the pharmacy, so he called 911 for Resident's #1's safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13	D 358		

-The Office Manager (OM) audited the eMARs monthly but had not said anything to him about Resident #1's FSBS values or FSBS rechecks, or that the current Novolog SSI order had been discontinued on 05/17/23.
-The order to discontinue Resident #1's Novolog SSI order on 05/17/23 should have been faxed to the pharmacy so that the pharmacy could remove the order from the eMAR.
-The administrative staff could also discontinue orders from the eMAR.
-He did not document his phone calls to the VA pharmacy to request a refill of Resident #1's Novolog SSI insulin pen.

Telephone interview with a technician from the VA pharmacy on 05/25/23 at 8:45am revealed:
-They had not received an order for Novolog SSI for Resident #1.
-If Resident #1 was ordered Novolog SSI from the hospital or ER, the doctor in the hospital would have to send a prescription directly to the VA Pharmacy.

Interview with the Resident Care Director (RCD) on 05/25/23 at 10:20am revealed:
-She was aware that Resident #1 was waiting for the delivery for some of his medications from the VA pharmacy but was not aware he had still not received his Novolog SSI insulin pen.
-The VA pharmacy told her that Resident #1's medications, including his Novolog insulin, would be shipped to the facility as soon as possible but had not yet arrived.
-She could not remember the exact date of her last call to the VA pharmacy for Resident #1.
-She had not faxed any of Resident #1's ER or hospital discharge summaries from May 2023 to the VA pharmacy.
-The Office Manager (OM) would have faxed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 14	D 358		

Resident #1's hospital and ER order changes to the VA pharmacy.
-She did not know if the hospital Resident #1 went to each time his FSBS was high faxed prescriptions to the VA pharmacy.
-She did not review the eMAR after each new medication order was received to ensure the medications were all present.
-The MA told her each time Resident #1 went to the ER for his FSBS values being high but did not always tell her if he returned to the facility with new orders that she needed to follow-up on.
-She was not aware of Resident #1 experiencing any symptoms on the days he was sent to the ER for high blood sugar.

Telephone interview with a representative from the facility's contracted pharmacy on 05/25/23 at 10:50am revealed:
-Resident #1 had a current order on file for Novolog SSI.
-They had no history of dispensing Novolog insulin to the facility for Resident #1, but could see that the back-up pharmacy had dispensed 1 Novolog insulin pen for him on 05/14/23 at 11:00am.

Interview with the OM on 05/25/23 at 11:43am revealed:
-She was not aware Resident #1 did not have a Novolog insulin pen available to administer as-needed or per SSI on some of the days he went to the ER for high FSBS values.
-When Resident #1's FSBS was high he never complained of being symptomatic.
-Whenever Resident #1's FSBS was over 450, the MA just called 911 and sent him to the ER.

Interview with the Administrator on 05/25/23 at 2:15pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 15	D 358		

-She was not aware Resident #1 did not have his Novolog SSI available for administration on the days he was sent to the ER for high FSBS values.
-She had picked Resident #1 up from the ER on 05/06/23 and the MA told her that he had all of Resident #1's medications available on the medication cart.
-Resident #1 did not have symptoms when his FSBS was high; the MA caught that the FSBS was high during his scheduled FSBS checks.
-The MA notified the facility's PCP about Resident #1's FSBS and ER trips weekly when she was at the facility doing her rounds.

Attempted telephone interview with the facility's PCP on 05/25/23 at 10:00am was unsuccessful.

Attempted telephone interview with Resident #1's VA PCP on 05/25/23 at 9:15am was unsuccessful.

Based on record reviews and interviews, the facility failed to administer SSI as ordered, recheck FSBS after SSI was administered per the SSI order and discontinue the SSI per physician's orders and continued to administer the SSI.

Refer to interview with Resident #1 on 05/24/23 at 1:00pm.

Refer to interview with the MA on 05/24/23 at 1:30pm.

Refer to telephone interview with a technician from the VA pharmacy on 05/25/23 at 8:45am.

Refer to interview with the RCD on 05/25/23 at 10:20am.

Refer to interview with the OM on 05/25/23 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 16 11:43am. Refer to interview with the Administrator on 05/25/23 at 2:15pm. c. Review of Resident #1's current FL2 dated 05/03/23 revealed an order to check fingerstick blood sugar (FSBS) once daily or as needed. Review of Resident #1's physician's order dated 05/17/23 revealed an order for Novolog insulin (a rapid-acting insulin used to treat high blood sugar) inject 2 units subcutaneously three times daily with meals, hold if FSBS less than 100. Review of Resident #1's May 2023 electronic medication administration record (eMAR) from 05/01/23 through 05/24/23 revealed: -There was an entry for Novolog insulin, inject 2 units subcutaneously with meals, hold for FSBS less than 100 scheduled at 7:30am, 11:30am and 4:30pm with an order start date of 05/17/23. -There was documentation Novolog 2 units were not administered from the 4:30pm dose on 05/18/23 through the 7:30am dose on 05/24/23. -The documented reason Novolog 2 units were not administered was that the medication was out of stock. -Resident #1's FSBS values from 05/17/23 through 05/24/23 ranged from 176 to 373. Observation of medication on hand for Resident #1 on 05/24/23 at 2:00pm revealed there was 1 Novolog insulin pen with a dispensed date of 05/14/23 and 75 units of insulin remaining in the pen. Interview with Resident #1 on 05/24/23 at 1:00pm revealed: -The medication aide (MA) checked his FSBS	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 17	D 358		

before meals and at bedtime because he had an order for Novolog sliding scale insulin (SSI) along with his scheduled insulin at mealtimes.
-He thought the MA had been administering his scheduled Novolog insulin along with his Novolog SSI three times daily with meals.

Interview with the MA on 05/24/23 at 1:30pm revealed:
-He was the live-in staff of the facility and worked all day almost every day as the MA.
-He got Resident #1's current Novolog insulin pen from the back-up pharmacy on 05/14/23 and he was still waiting on the VA to mail Resident #1's Novolog insulin supply to the facility.
-He had not been administering Resident #1's scheduled dose of Novolog insulin 2 units three times daily with meals because he only had one insulin pen so was using that insulin only for Resident #1's SSI order.
-The Office Manager (OM) audited the eMARs monthly, but had not said anything to him about Resident #1's scheduled dose of Novolog insulin not being administered.
-He did not document his phone calls to the VA pharmacy to request they expedite the delivery of Resident #1's Novolog insulin.
-The facility's PCP was aware he was not administering Resident #1's scheduled Novolog to him because he had not received a Novolog insulin from the VA pharmacy yet.

Telephone interview with a technician from the VA pharmacy on 05/25/23 at 8:45am revealed:
-The pharmacy had not received an order for Novolog 2 units three times daily with meals for Resident #1 on 05/17/23.
-Once the VA pharmacy received a new prescription, it could take up to two weeks to deliver the medication to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 18	D 358		

-If a medication such as insulin was needed as soon as possible, the facility could call the VA pharmacy and request to pick up the medication in person from the pharmacy that same day.
-They had not dispensed any Novolog insulin to the facility for Resident #1 in May 2023.

Interview with the Resident Care Director (RCD) on 05/25/23 at 10:20am revealed:
-She was aware that Resident #1 was waiting for the delivery for some of his medications from the VA pharmacy, but was not aware he had still not received his Novolog insulin.
-The VA pharmacy told her that Resident #1's medications, including his Novolog insulin, would be shipped to the facility as soon as possible, but Novolog insulin had not yet arrived.
-She could not remember the exact date of her last call to the VA pharmacy for Resident #1.
-The Office Manager (OM) would have faxed Resident #1's Novolog insulin order from 05/17/23 to the VA pharmacy.

Telephone interview with a representative from the facility's contracted pharmacy on 05/25/23 at 10:50am revealed:
-Resident #1 had a current order on file for Novolog 2 units three times daily with meals, hold for FSBS less than 100.
-They had no history of dispensing Novolog insulin to the facility for Resident #1.

Interview with the OM on 05/25/23 at 11:43am revealed:
-She had processed Resident #1's order on 05/17/23 for Novolog insulin 2 units three times daily with meals, hold if FSBS less than 100.
-Processing an order included faxing the order to both the VA pharmacy to dispense the medication and the facility's contracted pharmacy so they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 19	D 358		

could profile the order and add it to Resident #1's eMAR.
-She was not aware that Resident #1 had not received any Novolog insulin from the VA pharmacy since his order for scheduled Novolog insulin on 05/17/23.
-She was not aware that the MA had not been administering Resident #1's scheduled Novolog insulin in an attempt to conserve the insulin supply for his Novolog SSI order.
-Resident #1 had not had any episodes of high blood sugar or FSBS over 400 since 05/17/23 when his order for Novolog 2 units three times daily was written.

Interview with the Administrator on 05/25/23 at 2:15pm revealed she was not aware Resident #1 was not receiving scheduled Novolog 2 units three times daily as ordered.

Attempted telephone interview with the facility's PCP on 05/25/23 at 10:00am was unsuccessful.

Attempted telephone interview with Resident #1's VA PCP on 05/25/23 at 9:15am was unsuccessful.

Based on record reviews and interviews, the facility failed to administer Resident #1's scheduled Novolog insulin three times daily as ordered.

Refer to interview with Resident #1 on 05/24/23 at 1:00pm.

Refer to interview with the MA on 05/24/23 at 1:30pm.

Refer to telephone interview with a technician from the VA pharmacy on 05/25/23 at 8:45am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 20 Refer to interview with the RCD on 05/25/23 at 10:20am. Refer to interview with the OM on 05/25/23 at 11:43am. Refer to interview with the Administrator on 05/25/23 at 2:15pm. d. Review of Resident #1's physician's order dated 05/11/23 revealed an order for Lantus (a long-acting insulin used to treat high blood sugar) insulin, inject 10 units subcutaneously at bedtime. Review of Resident #1's May 2023 electronic medication administration record (eMAR) from 05/01/23 through 05/24/23 revealed: -There was an entry for Lantus insulin inject 10 units at bedtime scheduled at 8:00pm with an order start date of 05/11/23. -There was documentation Lantus insulin was not administered nightly from 05/11/23 through 05/23/23. -The documented reason Lantus was not administered was the medication was out of stock. -Resident #1's FSBS values from 05/11/23 through 05/23/23 ranged from 84 to 556. Observation of medication on hand for Resident #1 on 05/24/23 at 2:00pm revealed there was no Lantus insulin available for administration. Review of Resident #1's Progress Notes revealed there was no documentation that Lantus insulin had been ordered or administered to Resident #1 from 05/11/23 through 05/23/23. Interview with Resident #1 on 05/24/23 at 1:00pm	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 21	D 358		

revealed he had not received Lantus insulin since his order was written on 05/11/23 when he was being discharged from the hospital.

Interview with the MA on 05/24/23 at 1:30pm revealed:
-He was the live-in staff of the facility and worked all day almost every day as the MA.
-On 05/11/23, he checked Resident #1's FSBS at bedtime and the FSBS value was 512; he did not administer Lantus insulin because he did not yet have the Lantus on hand from the pharmacy, so he called 911 for Resident's #1's safety.
-On 05/12/23, he checked Resident #1's FSBS at bedtime and the FSBS value was 560; he did not administer Lantus insulin because he did not yet have the Lantus on hand from the pharmacy, so he called 911 for Resident's #1's safety, but he refused to go to the Emergency Room (ER).
-On 05/13/23, he checked Resident #1's FSBS at 8:00am and the FSBS value was 500; Resident #1 refused to go to the hospital, so he tried to contact the Administrator four times without a response.
-On 05/13/23, he checked Resident #1's FSBS at bedtime and the FSBS value was 485; he did not administer Lantus insulin because he did not yet have the Lantus on hand from the pharmacy, so he called 911 for Resident's #1's safety.
-The Office Manager (OM) audited the eMARs monthly but had not said anything to him about not administering Lantus to Resident #1 due to the medication being out of stock.
-He did not document his phone calls to the VA pharmacy to request the pharmacy to send Lantus as soon as possible.

Telephone interview with a technician from the VA pharmacy on 05/25/23 at 8:45am revealed the pharmacy last dispensed 1 insulin pen which was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 22 a 28-day supply of Lantus insulin for Resident #1 on 05/11/23 to take 10 units every night at bedtime but delivery of the insulin pen to the facility could take several days because it was mailed. Interview with the Resident Care Director (RCD) on 05/25/23 at 10:20am revealed: -She was aware Resident #1 was waiting for the delivery for some of his medications from the VA pharmacy, but was not aware he had still not received his Lantus insulin pen. -The OM would have faxed Resident #1's hospital and ER order changes to the VA pharmacy. Telephone interview with a representative from the facility's contracted pharmacy on 05/25/23 at 10:50am revealed: -Resident #1 had a current order on file from 05/11/23 for Lantus insulin, inject 10 units every night at bedtime. -They had no history of dispensing Lantus to the facility for Resident #1. Interview with the OM on 05/25/23 at 11:43am revealed: -She was aware that the MA had called the VA pharmacy within the previous week to request the Lantus insulin be mailed as soon as possible but was not aware that it still had not arrived. -She was not aware that the VA pharmacy had dispensed Lantus insulin for Resident #1 and it had not arrived in the mail yet. -When medications were delivered by mail to the facility for Resident #1, they first went to the main office to document receipt of the medication; she brought them to the facility to put on the medication cart. -When Resident #1's FSBS was high he never complained of being symptomatic.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 23 Interview with the Administrator on 05/25/23 at 2:15pm revealed: -She was not aware Resident #1 had not received Lantus insulin since it was ordered on 05/11/23. -Resident #1 did not have symptoms when his FSBS was high; the MA caught the FSBS was high during his scheduled FSBS checks. Attempted telephone interview with the facility's PCP on 05/25/23 at 10:00am was unsuccessful. Attempted telephone interview with Resident #1's VA PCP on 05/25/23 at 9:15am was unsuccessful. Based on record reviews and interviews, the facility failed to administer Lantus insulin from 05/11/23 through 05/23/23 because they failed to obtain the Lantus from their contracted pharmacy. Refer to interview with Resident #1 on 05/24/23 at 1:00pm. Refer to interview with the MA on 05/24/23 at 1:30pm. Refer to telephone interview with a technician from the VA pharmacy on 05/25/23 at 8:45am. Refer to interview with the RCD on 05/25/23 at 10:20am. Refer to interview with the OM on 05/25/23 at 11:43am. Refer to interview with the Administrator on 05/25/23 at 2:15pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 24	D 358		

e. Review of Resident #1's physician's order dated 11/16/22 revealed an order for gabapentin (a medication used to treat nerve pain) 300mg, take 2 capsules three times daily.

Review of Resident #1's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for gabapentin 300mg take 2 capsules three times daily scheduled at 8:00am, 12:00pm and 8:00pm.
-There was documentation gabapentin was not administered from 12:00pm on 04/18/23 through 8:00pm on 04/30/23.
-The documented reason gabapentin was not administered was the medication was out of stock.

Review of Resident #1's May 2023 eMAR from 05/01/23 to 05/24/23 revealed:
-There was an entry for gabapentin 300mg take 2 capsules three times daily scheduled at 8:00am, 12:00pm and 8:00pm.
-There was documentation gabapentin was not administered at 8:00am on 05/01/23 due to the medication being out of stock.

Observation of medication on hand for Resident #1 on 05/24/23 at 2:00pm revealed there was one bottle of gabapentin capsules with a dispensed date of 04/27/23 for a quantity of 90 capsules, and the bottle was half full.

Interview with the medication aide (MA) on 05/24/23 at 1:30pm revealed:
-The Office Manager (OM) audited the eMARs monthly, but had not said anything to him about not administering gabapentin to Resident #1 at the end of April 2023 due to it being out of stock.
-He did not document his phone calls to the VA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 25	D 358		

pharmacy to request the pharmacy send a refill of gabapentin for Resident #1.

Telephone interview with a technician from the VA pharmacy on 05/25/23 at 8:45am revealed:
-The pharmacy last dispensed gabapentin 300mg capsules to the facility for Resident #1 on 04/27/23 for 180 capsules which was a 30-day supply.
-Prior to 04/27/23, the pharmacy dispensed 180 capsules of gabapentin 300mg to the facility for Resident #1 on 02/07/23.

Interview with the Resident Care Director (RCD) on 05/25/23 at 10:20am revealed:
-She was aware Resident #1 had ran out of gabapentin the last couple of weeks of April 2023.
-Resident #1 sometimes complained of various pains, but did not describe the nature of the pain or where the pain was located.

Telephone interview with a technician from the facility's contracted pharmacy on 05/25/23 at 10:50am revealed:
-Resident #1 had a current order profiled for gabapentin 300mg, take 2 capsules three times daily.
-They had never dispensed gabapentin for Resident #1.

Interview with Resident #1 on 05/25/23 at 11:15am revealed:
-He was aware that he did not receive gabapentin from 04/18/23 through 05/01/23.
-He took gabapentin for pain that he had in his back, legs and feet.
-He did not have pain every day; he usually had pain a couple of times per week.
-When he had pain, it was usually rated an 8 out of 10, with 10 being the worst pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 26	D 358		

-When he had ran out of gabapentin, his pain was closer to being a 10 out of 10.

Interview with the OM on 05/25/23 at 11:43am revealed:
-She was aware Resident #1 ran out of gabapentin at the end of April 2023.
-Resident #1 had not complained to her about pain when he ran out of gabapentin.

Interview with the Administrator on 05/25/23 at 2:15pm revealed she was not aware Resident #1 had not received gabapentin from 04/18/23 to 05/01/23 due to the medication running out.

Attempted telephone interview with the facility's PCP on 05/25/23 at 10:00am was unsuccessful.

Attempted telephone interview with Resident #1's VA PCP on 05/25/23 at 9:15am was unsuccessful.

Refer to interview with Resident #1 on 05/24/23 at 1:00pm.

Refer to interview with the MA on 05/24/23 at 1:30pm.

Refer to telephone interview with a technician from the VA pharmacy on 05/25/23 at 8:45am.

Refer to interview with the RCD on 05/25/23 at 10:20am.

Refer to interview with the OM on 05/25/23 at 11:43am.

Refer to interview with the Administrator on 05/25/23 at 2:15pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
D 358	Continued From page 27	D 358		

f. Review of Resident #1's physician's order dated 04/05/23 revealed an order for ondansetron (an anti-emetic medication used to treat nausea) 4mg, take 1 tablet four times daily.

Review of Resident #1's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for ondansetron 4mg, take 1 tablet 4 times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation ondansetron was administered four times daily except at 4:00pm on 04/06/23 when he refused, on 8:00pm on 04/26/23 when he refused, and at 12:00pm and 8:00pm on 04/27/23 when he was out of the facility.

Review of Resident #1's May 2023 eMAR from 05/01/23 to 05/24/23 revealed:
-There was an entry for ondansetron 4mg, take 1 tablet 4 times daily scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation ondansetron was not administered from 4:00pm on 05/16/23 through 8:00am on 05/24/23 due to the medication being out of stock.

Observation of medication on hand for Resident #1 on 05/24/23 at 2:00pm revealed there was no ondansetron available for administration.

Interview with Resident #1 on 05/24/23 at 1:00pm revealed:
-He was prescribed ondansetron four times daily because he had been having gastrointestinal upset which was worse in April 2023 when the medication was prescribed.
-He had not received his ondansetron for a couple of weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 28	D 358		

-The MA told him he was not receiving ondansetron because he was waiting on the VA pharmacy to send a refill to the facility.
-He had not had any symptoms of nausea since his ondansetron ran out except for that morning but he thought it was because he ate sausage for breakfast.

Interview with the MA on 05/24/23 at 1:30pm revealed:
-Resident #1 ran out of ondansetron to administer to Resident #1 a couple of weeks prior.
-He called the VA pharmacy phone number and requested a refill for Resident #1's ondansetron from the automated refill system.
-He had not documented his phone calls to the VA pharmacy to request a refill of ondansetron for Resident #1.
-Resident #1 had not complained about nausea or vomiting since he ran out of ondansetron except for earlier that morning he had some nausea from eating sausage with breakfast.

Telephone interview with a representative from the VA pharmacy on 05/25/23 at 8:45am revealed:
-The pharmacy last dispensed ondansetron to the facility for Resident #1 on 03/17/23 for a previous order for take 2 tablets every 6 hours as needed.
-They had not received an order for Resident #1 to take ondansetron 4mg 1 tablet 4 times daily scheduled.

Interview with the Resident Care Director (RCD) on 05/25/23 at 10:20am revealed:
-She was aware Resident #1 was waiting for the delivery for some of his medications from the VA pharmacy including his ondansetron.
-She was the staff responsible for calling and completing follow-up with the VA pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 29	D 358		

regarding Resident #1's medications.
-She could not remember the exact date of her last call to the VA pharmacy for Resident #1.
-Resident #1 had not complained of experiencing any symptoms of nausea or vomiting in the previous couple of weeks since he ran out of ondansetron.

Telephone interview with a representative from the facility's contracted pharmacy on 05/25/23 at 10:50am revealed:
-Resident #1 had a current order on file from 04/05/23 for ondansetron 4mg take 1 tablet 4 times daily.
-On 04/05/23, the pharmacy dispensed 120 tablets of ondansetron 4mg for Resident #1 which was a 30 day supply.
-The pharmacy had not received a refill request for ondansetron for Resident #1.

Interview with the Office Manager (OM) on 05/25/23 at 11:43am revealed:
-She had not received a delivery of ondansetron tablets for Resident #1 from the VA pharmacy.
-She was not aware that Resident #1 had continuously missed doses of ondansetron.

Interview with the Administrator on 05/25/23 at 2:15pm revealed she was not aware Resident #1 had not received ondansetron since 05/16/23 due to the medication running out.

Attempted telephone interview with the facility's PCP on 05/25/23 at 10:00am was unsuccessful.

Attempted telephone interview with Resident #1's VA PCP on 05/25/23 at 9:15am was unsuccessful.

Refer to interview with Resident #1 on 05/24/23 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 30 1:00pm. Refer to interview with the MA on 05/24/23 at 1:30pm. Refer to telephone interview with a technician from the VA pharmacy on 05/25/23 at 8:45am. Refer to interview with the RCD on 05/25/23 at 10:20am. Refer to interview with the OM on 05/25/23 at 11:43am. Refer to interview with the Administrator on 05/25/23 at 2:15pm. _____ Interview with Resident #1 on 05/24/23 at 1:00pm revealed: -He received all his medications from the Department of Veteran's Affairs (VA) pharmacy. -The VA pharmacy took a long time to process prescriptions and mail them to the facility. -The staff were supposed to order his medications at least 2 weeks before they ran out, so the VA pharmacy had time to send the medication. Interview with the medication aide (MA) on 05/24/23 at 1:30pm revealed: -Resident #1 received his medications from the Department of VA pharmacy. -He was told by the VA pharmacy that he was not able to go to the VA pharmacy and pick up Resident #1's medications because they had to be mailed. -He was told that if he requested the subsequent refill from the VA pharmacy early, it would pend in a queue and the VA pharmacy would refill the medication as soon as insurance would allow.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

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D 358	Continued From page 31	D 358		

-When he received medications for Resident #1 in the mail from the VA, he always called the pharmacy that same day to request the next refills.

Telephone interview with a technician from the VA pharmacy on 05/25/23 at 8:45am revealed:
-The facility should request medication refills at least 2 weeks before the medication ran out.
-The day the facility received a shipment of medication they were able to call the pharmacy and request the next refill.
-The facility staff could use the automated medication refill option in the VA phone system to request medication refills unless a medication did not have any refills available, and a new prescription would be needed.
-If a medication was needed as soon as possible, the facility could call the VA pharmacy and request to pick up the medication in person from the pharmacy that same day.
-Once the VA pharmacy received a new prescription, it could take up to two weeks to deliver the medication to the facility.

Interview with the Resident Care Director (RCD) on 05/25/23 at 10:20am revealed:
-She was the staff responsible for calling and completing follow-up with the VA pharmacy regarding Resident #1's medications.
-She was not aware of anyone completing an audit of Resident #1's electronic medication administration record (eMAR) or medications in the previous three months.
-She had a VA communication book where she documented each time she called the VA to request Resident #1's medications, but she could not find the book.
-She could not remember the exact date of her last call to the VA pharmacy for Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 32 -There were currently no staff responsible for completing audits of the eMARs or medication carts. Interview with the Office Manager (OM) on 05/25/23 at 11:43am revealed: -The facility pharmacy audited the residents' eMARs and medication carts quarterly, but there were currently no facility staff who completed eMAR or medication cart audits. -It usually took the VA pharmacy a week or two to get medication refills processed and mailed to the facility. -When medications were delivered by mail to the facility for Resident #1, they first went to the main office to document receipt of the medication; she brought them to the facility to put on the medication cart. -She was responsible for receiving new medication orders and ensuring they were faxed to the facility's contracted pharmacy and the VA pharmacy if needed. -The pharmacy audited the residents' eMARs and medication carts quarterly, but there were currently no facility staff who completed eMAR or medication cart audits. -She was aware that Resident #1 did not always receive his medications from the VA before his medication supply ran out. Interview with the Administrator on 05/25/23 at 2:15pm revealed: -She expected the MA to notify her if he was not able to get a prescription from the VA pharmacy and she would follow-up with the VA pharmacy or have the RCD call the VA pharmacy regarding the medication refill daily. -The OM checked the eMAR documentation system daily for medications not administered. -The OM completed medication cart audits	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034107	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 33 quarterly in between the time when the pharmacy did their medication cart audits. -The MAs were expected to call the VA pharmacy to request a medication refill on the same day they received shipment of the medication in mail so that the VA pharmacy would have the refill request already by the time the medication needed to be reordered. _____ The facility failed to ensure medications were administered as ordered for Resident #1 who had an order for as-needed rapid-acting insulin which was not available for administration and resulted in the resident going to the Emergency Room four times to be treated for high blood sugar; an order for sliding-scale insulin with directions to recheck FSBS if over 400 which was not documented being done which placed the resident at risk for increased in blood sugar levels, and an order to discontinue the sliding scale insulin which had not been discontinued placing the resident at risk for hypoglycemia; an order for long-acting insulin at bedtime that was not administered placing the resident at risk for increased blood sugar levels; and an order for gabapentin which was not administered 39 times from 04/18/23 through 05/01/23 and resulted in the resident experiencing increased pain. This failure placed residents at substantial risk for serious physical harm which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/25/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED, JUNE 24, 2023.	D 358		