STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345229	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - SHELBY	**1101 NORTH MORGAN STREET SHELBY, NC 28150**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/18/24 through 11/21/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1J1G11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/18/24 through 11/21/24. Event ID# 1J1G11. The following intakes were investigated: NC00210964, NC00218958, NC00216840, NC00218943, NC00223637, NC00223241, NC00223364, NC00223498, and NC00223581. 25 of the 25 complaint allegations did not result in a deficiency.	F 000		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be	F 757		12/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/11/2024

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F 757	Continued From page 1 reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, and Nurse Practitioner (NP), Consulting Pharmacist and staff interviews, the facility failed to check finger-stick blood sugar (FSBS) for a resident that received insulin injections twice daily for 1 of 3 residents reviewed for unnecessary medications (Resident #40). The findings included: Resident #40 was admitted to the facility on 9/4/2019 with multiple diagnoses which included, a right side below the knee amputation, type 2 diabetes mellitus and end stage renal disease. Review of the most recent quarterly Minimum Data Set (MDS) dated 11/8/2024 revealed Resident #40 was cognitively intact and required substantial to max assist for most Activities of Daily Living (ADLs). The MDS also revealed Resident #40 was coded that she received insulin injections. Documentation on the care plan last reviewed on 11/8/2024 revealed Resident #40 had type 2 diabetes mellitus with interventions that included: to assess for hyperglycemic episodes such as acetone breath, polyuria and flushed skin, during rounds and prn. Treat as per physician orders. Assess for hypoglycemic episodes such as sweating, chills, rapid weak pulse, tachycardia and tremors, during rounds and prn. Follow facility protocol for any acute signs and symptoms	F 757	POC F757 This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Affected Resident Orders were written by Bobbie Blanton, Nurse Practitioner (NP) on November 19, 2024, to implement Fingerstick blood sugar checks (FSBS) on resident #40 twice daily. Resident #40 did not experience any adverse effects related to alleged deficient practice. Blood sugar results were 149 when checked. Residents with potential to be affected. The Director of Nursing (DON) completed an audit on all residents in the facility receiving Insulin on November 22, 2024. There was one other resident receiving insulin daily without orders for FSBS. Orders were obtained from the NP to implement FSBS daily. Blood sugar results were 132 when checked. No other	

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F 757	Continued From page 2 of hyper/hypoglycemic episodes. During an interview with Resident #40 on 11/28/2024 at 11:28am, Resident #40 voiced she was a diabetic and was concerned that her blood sugar was no longer being checked. Resident #40 stated that she received 14 units of insulin in the morning and 16 units in the evening, but the staff was no longer checking her blood sugar. Resident #40 stated she did not know why they were stopped. Resident #40 stated she had episodes of increased sleepiness since her blood sugars had stopped being checked. A review of Resident #40's Physicians' orders revealed Resident #40 had active orders for Levemir Insulin 100unit/ml Administer 16 units daily at 8pm with a start date of 6/3/2022, and Levemir Insulin 100unit/ml Administer 14 units daily at 8am with a start date of 4/8/2024. Review of the Nurse Practitioner (NP) note dated 9/25/2024 revealed Resident #40's lispro (short acting insulin) sliding scale order would be discontinued. Note also revealed that the NP educated Resident #40 on the importance of maintaining a balanced diet and monitoring blood sugar levels. Further review of Resident #40's Physicians orders revealed an order for insulin lispro (short acting insulin) with a sliding scale was discontinued on 9/25/2024. Review of the Point-of-Care Blood Sugar Summary report for Resident #40 revealed no FSBS had been recorded since the morning of 9/25/2024.	F 757	residents were affected by the alleged deficient practice. Systemic Changes All licensed nurses were educated on adequate monitoring for adverse effects of residents receiving insulin, which includes obtaining FSBS per Physician orders. When verifying orders to discontinue sliding scale insulin, the licensed nurse will ensure that residents receiving routine insulin continue with orders for FSBS. The education was completed on Dec. 11, 2024. Any licensed nurses out on leave or PRN status will be educated prior to returning to duty by the DON or Designee. Newly hired licensed nurses are educated on this process during orientation by the Staff Development Coordinator, DON or Designee. An audit tool was developed to ensure compliance with the plan of correction. The audit contains the following. FSBS being monitored for the resident receiving insulin. The DON/Designee will complete audits on 25% of residents receiving insulin weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of the audits will determine the need for further monitoring. The DON will bring the audits to the monthly Quality Assurance and Performance Improvement (QAPI)	

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F 757	Continued From page 3 Record review revealed Resident #40 had an order for HbA1c every 3 months. HbA1c completed on 4/16/2024 with results of 6.7, on 7/15/2024 with results of 6.6, and on 10/15/2024 with results of 6.5. (HbA1c Range 5.0-6.1) During an interview on 11/19/2024 at 12:52pm Nurse #2 stated the Nurse Practitioner (NP) wrote the order for Resident #40's lispro insulin sliding scale to be discontinued and that she (Nurse #2) verified the order. Nurse #2 stated that orders were verified by reviewing the order from the NP, and making sure the order in the computer electronic Medication Administration Record (eMAR) was entered into the system correctly. Nurse #2 stated that orders were normally verified by the charge nurse, but orders could also be verified by the hall nurse. Nurse #2 stated that FSBS are dependent on what is ordered by the provider. Nurse #2 stated that most of the time when a resident received insulin injections, the resident also has FSBS completed. Nurse #2 was not aware of any instances of Resident #40 having increased sleepiness reported, but stated Resident #40 did stay up late into the evening on her phone. During an interview on 11/19/2024 at 1:29pm the Nurse Practitioner (NP) verified she had entered the order to discontinue the lispro insulin sliding scale for Resident #40 into the computer. The NP stated she did not intend for the FSBS to be discontinued, only the sliding scale insulin and that she would fix it. The NP stated that FSBS can be tied into the order for a medication when entered into the system and that is probably why the FSBS was stopped when the sliding scale was discontinued.	F 757	Committee meeting x 3 months for review and further recommendations. Completion date: December 11, 2024	

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F 757	Continued From page 4	F 757		

During an interview on 11/20/2024 at 8:56am Nurse #3, stated the Med Aide (MA) checked the FSBS and Nurse #3 saw the results on the computer and then administered insulin injections. Nurse #3 stated as far as she knew every resident that received insulin also had FSBS completed. Nurse #3 came back later that day at 2:18 pm and stated she was incorrect earlier and stated FSBS for residents are based on the order from the provider.

During an interview on 11/20/2024 at 2:16pm Nurse #1 stated she checked her own FSBS on her hall because she did not normally have an MA assigned. Nurse #1 stated the residents who receive insulin also have FSBS completed.

During an interview on 11/20/2024 at 2:20pm. Nursing Assistant (NA) #1 stated she checked the computer and completed the FSBS that were ordered, then documented them on the eMAR. NA #1 was not aware of all the residents that received insulin.

During an interview on 11/19/2024 at 1:51pm the Consulting Pharmacist stated he was unaware that Resident #40 did not have a current order for FSBS. The Consulting Pharmacist stated anyone receiving insulin should have some FSBS completed. The Consulting Pharmacist would recommend at least once daily but knew some providers ordered FSBS for every other or every third day. The Consulting Pharmacist stated when he completed his review in October the September FSBS were reviewed. He stated the October MAR would be reviewed on his next visit in November 2024. The Consulting Pharmacist stated if he had seen during his review there were no FSBS, he would have questioned why they

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F 757	Continued From page 5 were stopped. A joint interview was conducted with the Administrator and the Director of Nursing (DON) on 11/20/2024 at 3:23pm. The DON and Administrator were unaware that Resident # 40 had not had FSBS from 9/25/2024, but the Administrator asked if Resident #40 had a HbA1c. The DON verified Resident #40 had a HbA1c of 6.5 on 10/15/2024. The DON verified that after orders are entered by the NP a nurse would verify the order before it was changed on the eMAR. The DON also verified that insulin and FSBS orders can be connected on the eMAR. The DON stated that it is up to the provider if a resident received FSBS while on insulin. The Administrator stated FSBS are looked at on a case-by-case basis determined by the provider. The Administrator stated the Medical Director had mentioned there were papers that suggested the use of HbA1c to monitor instead of FSBS would be considered. The DON stated they did not have a policy regarding FSBS use for diabetics. During a telephone interview on 11/21/23 at 8:10am the Medical Director stated residents were looked at on a case-by-case basis regarding orders for FSBS. The Medical Director stated there is talk starting, regarding using the HGBA1C for monitoring but did not mention any study or papers supporting this.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		12/11/24

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F 761	Continued From page 6 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to record an open date on multi-dose insulin pens, failed to discard expired insulin pens, and failed to store an unopened insulin pen in the refrigerator for 1 of 2 medication carts reviewed for medication storage (Hall A medication cart). The findings included: Review of the manufacturer's package insert for Levemir (Insulin detemir) flexpen stated to store unopened Insulin detemir insulin pens in a refrigerator and in-use (opened) Insulin detemir pens at room temperature for 42 days and then discard. Review of the manufacturers' instructions	F 761	POC F761 This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Affected resident All opened and undated, expired and improperly stored insulin pens were removed from the medication cart on	

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F 761	Continued From page 7 for Glargine insulin pen, Novolog insulin pen, and Lispro insulin pen, stated the insulin pens may be used for 28 days after opening, then discard. An observation of the medication cart on Hall A was conducted on 11/20/2024 at 11:05 AM with Nurse #1. The observation revealed an opened Glargine insulin pen and an opened Novolog insulin pen that were not dated. The medication cart observation also revealed an opened insulin detemir flexpen with an open date of 08/23/2024 and an opened Lispro insulin pen with an open date of 09/24/2024. The observation further revealed an unopened insulin pen was stored in the right top drawer of the medication cart and was labeled as "refrigerate until opened." An interview was conducted with Nurse #1 on 11/20/2024 at 11:11 AM who stated insulin should be stored in the refrigerator until ready to use and all insulin pens should have an open date with a 28-day expiration date. Nurse #1 further stated that she did not realize the insulin pens were not dated and that two insulin pens were expired. An interview was conducted with the Director of Nursing (DON) on 11/20/2024 at 11:50 AM. The DON revealed all insulin pens should have been labeled when opened for use with a 28-day expiration date sticker. The DON indicated that all nurses were responsible for checking medications in the medication carts for expired medications. She also stated that all unopened insulin pens should be stored in the refrigerator until ready for use and that no expired medications should be available for use in the medication carts.	F 761	hallway A immediately on November 21, 2024, by the Director of Nursing (DON). Resident with Potential to be Affected The DON and Unit Manager (UM) checked all medication carts in the facility to ensure that there were no opened and undated, expired or improperly stored insulin pens on November 22, 2024. No additional opened and undated, expired or improperly stored insulin pens were observed in any cart in the facility. No resident was adversely affected by the alleged deficient practice. Systemic Changes All licensed nurses and medication aides were educated on the policy regarding proper labeling and storage of insulin pens by the DON, UM and/or their designee. This education included that all opened insulin pens must be dated; all expired insulin pens must be removed from the medication cart prior to the expiration date; and unopened insulin pens must be kept refrigerated. This education was completed by December 4, 2024. Any licensed nursing staff or medication aide out on leave or PRN (as needed) status will be educated prior to returning to duty by the DON, UM and/or their designee. Newly hired licensed nursing staff and medication aides are educated on this process during orientation by the Staff Development Coordinator/DON.	

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F 761	Continued From page 8	F 761	Monitoring An audit tool was developed to ensure compliance with the plan of correction. The audit tool contains the following: 1. Are there any opened and undated, expired or improperly stored insulin pens on the medication carts? The DON/designee will audit 50% of all medication carts weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of the audits will determine the need for further monitoring. The DON will bring the results of these audits to the monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting x 3 months for further review and recommendations. Completion date: December 11, 2024	