STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL042007	A. BUILDING: _____ B. WING _____	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF LAKE GASTON	206 NORTH MOSBY AVE LITTLETON, NC 27850

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 10/11/23 to 10/12/23. The complaint investigation was initiated by the Halifax County Department of Social Services on September 21, 2023.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (#1) related to notifying the primary care provider (PCP) of fingerstick blood sugars (FSBS) outside of parameters. The findings are: Review of Resident #1's current FL-2 dated 09/09/23 revealed: -Diagnosis included type 2 diabetes. -There was an order to check fingerstick blood sugar (FSBS) once daily, notify primary care provider (PCP) if FSBS less than 150 or greater than 400. Review of Resident #1's physician order sheet dated 07/28/23 revealed there was an order to check FSBS once daily, notify PCP if FSBS less	D 276		

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D 276	Continued From page 1 than 150 or greater than 400. Review of Resident #1's progress note dated 09/22/23 revealed there was an order to increase FSBS checks to twice a day. Review of Resident #1's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS once daily, notify PCP if FSBS less than 150 or greater than 400 scheduled for 6:30am. -FSBS was documented as 140 at 6:30am on 08/06/23. -FSBS was documented as 141 at 6:30am on 08/10/23. -FSBS was documented as 131 at 6:30am on 08/11/23. -FSBS was documented as 120 at 6:30am on 08/12/23. -FSBS was documented as 148 at 6:30am on 08/13/23. -FSBS was documented as 136 at 6:30am on 08/15/23. -FSBS was documented as 145 at 6:30am on 08/16/23. -FSBS was documented as 100 at 6:30am on 08/17/23. -FSBS was documented as 105 at 6:30am on 08/21/23. -FSBS was documented as 122 at 6:30am on 08/24/23. -FSBS was documented as 86 at 6:30am on 08/31/23. -There was no documentation that Resident #1's PCP had been notified of these FSBSs below 150. Review of Resident #1's September 2023 eMAR revealed:	D 276		

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D 276	Continued From page 2 -There was an entry to check FSBS once daily, notify PCP if FSBS less than 150 or greater than 400 scheduled for 6:30am. -FSBS was documented as 125 at 6:30am on 09/01/23. -FSBS was documented as 122 at 6:30am on 09/04/23. -FSBS was documented as 138 at 6:30am on 09/09/23. -FSBS was documented as 140 at 6:30am on 09/11/23. -FSBS was documented as 130 at 6:30am on 09/12/23. -FSBS was documented as 109 at 6:30am on 09/18/23. -FSBS was documented as 136 at 6:30am on 09/20/23. -FSBS was documented as 135 at 6:30am on 09/24/23. -There was no documentation that Resident #1's PCP had been notified of these FSBSs below 150. Review of Resident #1's October 2023 eMAR revealed: -There was an entry to check FSBS twice a day, notify PCP if FSBS less than 150 or greater than 400 scheduled for 7:00am and 8:00pm. -FSBS was documented as 97 at 7:00am on 10/01/23. -FSBS was documented as 86 at 7:00am on 10/04/23. -FSBS was documented as 109 at 7:00am on 10/06/23. -FSBS was documented as 148 at 7:00am on 10/09/23. -FSBS was documented as 93 at 8:00pm on 10/09/23. -FSBS was documented as 126 at 7:00am on 10/10/23.	D 276		

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-FSBS was documented as 135 at 8:00pm on 10/10/23.
-FSBS was documented as 135 at 7:00am on 10/11/23.
-There was no documentation that Resident #1's PCP had been notified of these FSBSs below 150.

Review of Resident #1's progress notes revealed:
-Resident #1's PCP was notified of a FSBS of 93 on 08/09/23.
-Resident #1's PCP was notified of a FSBS of 98 on 09/06/23 and there was an order to hold Lantus.
-Resident #1's PCP was notified of a FSBS of 100 on 09/08/23 and there was an order to hold Lantus.
-There was no other documentation of Resident #1's PCP being notified of FSBSs below 150.

Interview with Resident #1 on 10/12/23 at 3:00pm revealed she had not had any signs and symptoms of a low blood sugar over the past few months.

Interview with a medication aide (MA) on 10/12/23 at 2:42pm revealed:
-Resident #1 had orders to notify her PCP if her FSBS was below 150 or greater than 400 so the PCP should be notified by the MA who checked her FSBS if it was too low or too high.
-Resident #1's FSBS were checked on 3rd shift, so she did not check FSBSs for the resident.
-PCPs were notified of FSBSs in a computer application.

Review of the computer application used to notify PCPs on 10/12/23 at 12:10pm revealed:
-There was documentation that Resident #1's PCP had been notified of FSBSs below 150 on

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D 276	Continued From page 4 08/02/23, 08/09/23, 08/14/23, 09/06/23, and 09/08/23. -There was no documentation of Resident #1's PCP being notified of any other FSBSs. Interview with the Resident Care Coordinator (RCC) on 10/12/23 at 3:35pm revealed: -MAs were expected to follow orders and notify Resident #1's PCP if her FSBS was below 150 or greater than 400. -MAs notified PCPs using a computer application. -It was important that MAs notified Resident #1's PCP of FSBS out of range to see if they should administer insulin or not and to see if they needed to recheck Resident #1's FSBS. Interview with the Administrator on 10/12/23 at 4:03pm revealed: -MAs used a computer application to notify resident's PCPs of FSBSs outside of parameters. -She expected MAs to follow PCP orders and notify them if Resident #1's FSBS was below 150 or greater than 400. Telephone interview with Resident #1's PCP on 10/12/23 at 3:22pm revealed: -She ordered facility staff to notify her of a FSBS below 150 for Resident #1 because she wanted to make sure her FSBSs were not dropping too low. -She expected to be notified as ordered for a FSBS below 150 for Resident #1 but she would probably not have ordered anything differently if she was notified. -She was trying to track Resident #1's FSBS to see if her medications needed to be changed.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 5 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: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 1 of 5 sampled residents (#1) including a medication used to treat high blood sugar and a medication used to treat skin conditions. The findings are: Review of Resident #1's current FL-2 dated 09/09/23 revealed diagnosis included type 2 diabetes. a. Review of Resident #1's current FL-2 dated 09/09/23 revealed: -There was an order for Lantus (a long-acting insulin used to treat high blood sugars) 50 units once daily, hold if FSBS (fingerstick blood sugar) less than 130. -There was an order to check FSBS once daily notify primary care provider (PCP) if FSBS less than 150 or greater than 400, check before Lantus. Review of Resident #1's physician order sheet dated 07/28/23 revealed: -There was an order to check FSBS once daily, notify PCP if FSBS less than 150 or greater than	D 358		

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D 358	Continued From page 6 400. -There was an order for Lantus 50 units once daily, hold if FSBS less than 130. Review of Resident #1's progress note dated 09/22/23 revealed there was an order to increase FSBS checks to twice a day. Review of Resident #1's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS once daily, notify PCP if FSBS less than 150 or greater than 400, check before Lantus scheduled for 6:30am. -There was an entry for Lantus inject 50 units once daily, hold if FSBS is less than 130 scheduled at 8:00am. -FSBS was documented as 110 at 6:30am on 08/02/23. -Lantus 50 units was documented as administered at 8:00am on 08/02/23 when it should have been held. -FSBS was documented as 120 at 6:30am on 08/12/23. -Lantus 50 units was documented as administered at 8:00am on 08/12/23 when it should have been held. -FSBS was documented as 136 at 6:30am on 08/12/23. -Lantus 50 units was documented as not administered when it should have been administered. Review of Resident #1's September 2023 eMAR revealed: -There was an entry to check FSBS once daily, notify PCP if FSBS less than 150 or greater than 400, check before Lantus scheduled for 6:30am. -There was an entry for Lantus inject 50 units once daily, hold if FSBS is less than 130	D 358		

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scheduled at 8:00am.
-FSBS was documented as 125 at 6:30am on 09/01/23.
-Lantus 50 units was documented as administered at 8:00am on 09/01/23 when it should have been held.
-FSBS was documented as 100 at 6:30am on 09/08/23.
-Lantus 50 units was documented as administered at 8:00am on 09/08/23 when it should have been held.

Review of Resident #1's October 2023 eMAR revealed.
-There was an entry to check FSBS twice a day, notify PCP if FSBS less than 150 or greater than 400 scheduled for 7:00am and 8:00pm.
-There was an entry for Lantus inject 50 units once daily, hold if FSBS is less than 130 scheduled for 8:00am.
-FSBS was documented as 97 at 7:00am on 10/01/23.
-Lantus 50 units was documented as administered at 8:00am on 10/01/23 when it should have been held.

Interview with Resident #1 on 10/12/23 at 3:00pm revealed:
-She received Lantus 50 units every day, but it was supposed to be held if her blood sugar was less than 130.
-As far as she knew the medication aides (MA) did not administer Lantus to her if her blood sugar was less than 130.
-She had not had any signs and symptoms of low blood sugar over the past few months.

Interview with a medication aide (MA) on 10/12/23 at 2:42pm revealed:
-Resident #1 received Lantus once a day unless

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her FSBS was less than 130.
-The 3rd shift MA wrote Resident #1's FSBS on a piece of paper for her so she knew what Resident #1's blood sugar was.
-She knew not to administer Resident #1's Lantus if her FSBS was less than 130 so she was not sure why she administered Lantus to her on 08/12/23 and 09/08/23.

Interview with the Resident Care Coordinator (RCC) on 10/12/23 at 3:35pm revealed:
-MAs should follow directions on the resident's eMAR and administer medications as they were ordered.
-MAs should not administer Lantus to Resident #1 when her FSBS was less than 130.
-The MA was expected to administer Lantus to Resident #1 when her FSBS was 136.

Interview with the Administrator on 10/12/23 at 4:03pm revealed she expected MAs to triple check the medication order before administering Lantus to Resident #1 so they would not administer it when they should not or not administer it when they should.

Telephone interview with Resident #1's PCP on 10/12/23 at 3:22pm revealed:
-She ordered for Resident #1's Lantus to be held if her FSBS was less than 130 because she did not want her FSBS to drop too low.
-She usually did not order FSBS parameters for Lantus because it was a long-acting insulin and would not usually make a resident's FSBS drop right away.
-If Lantus was administered when Resident #1's FSBS was less than 130 it could cause her FSBS to drop too low during the night and the resident might not be aware of it.
-If Resident #1's FSBS dropped too low it could

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cause the resident to become sweaty or unresponsive and she would not be able to call for help.
-Resident #1's FSBS dropping too low could cause the resident to have to go to the hospital.
-Resident #1's Lantus should not have been held for a FSBS of 136.
-Holding Resident #1's Lantus when it should have been administered could cause Resident #1's FSBS to become too high and cause the resident to not feel well and could cause headache, increased thirst, or frequent urination.

b. Review of Resident #1's prescription dated 10/02/23 revealed there was an order for clobetasol 0.05% (a cream used to treat skin conditions) apply to rash on arms twice daily 2 days on and 2 days off.

Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for clobetasol ointment 0.05% apply topically to rash on arms twice a day 2 days on and 2 days off scheduled for administration at 8:00am and 8:00pm.
-Clobetasol 0.05% was documented as administered at 8:00am and 8:00pm on 10/04/23 to 10/12/23 and at 8:00pm on 10/04/23 to 10/11/23 except on 10/08/23 when it was documented as refused.
-Clobetasol 0.05% was documented as administered twice a day everyday instead of twice a day 2 days on and 2 days off.

Observation of Resident #1's medication on hand on 10/12/23 at 2:40pm revealed there was a tube of clobetasol 0.05% dispensed on 10/02/23 with instructions to apply topically to rash on arms twice a day 2 days on, 2 days off.

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D 358	Continued From page 10 Interview with Resident #1 on 10/12/23 at 11:03am revealed: -She went to a dermatologist because she had a rash on her arms. -The dermatologist ordered cream to be applied to her arms twice a day 2 days on and 2 days off. -The medication aides (MA) were applying the cream to her arms twice a day every day. -Because so many different MAs administered her medications it was hard to keep up with when she was supposed to use the cream and when she was not so she started putting marks on a calendar so she would know when she was supposed to use the cream and when she was not. -Most of the time the MAs applied the cream to her arms anyway. -The rash on her arms was much better than it was before she started using the cream. Observation of Resident #1's arms on 10/12/23 at 11:03am revealed: -There were small areas of rashes on both arms. -There was no redness or irritation seen on the skin on her arms. Interview with a MA on 10/12/23 at 11:46am revealed: -She noticed that the directions on the eMAR for Resident #1's clobetasol stated to administer it 2 days on and 2 days off. -Resident #1's clobetasol popped up on the eMAR to be administered every day. -She had been instructed by the Resident Care Coordinator (RCC) to administer a medication if it popped up on the eMAR to be administered so that was why she administered it even though the directions stated something different.	D 358		

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D 358	Continued From page 11 Interview with a second MA on 10/12/23 at 2:50pm revealed: -The instructions on the eMAR were for Resident #1's clobetasol to be administered 2 days on and 2 days off. -She administered Resident #1's clobetasol twice a day every day because it popped up on the eMAR to be administered. -Resident #1 questioned her one day if she was supposed to receive clobetasol or not. -Resident #1 told her that she was not supposed to receive the clobetasol that day, so she did not administer it and marked it as refused on the eMAR. Interview with the RCC on 10/12/23 at 3:35pm revealed: -She expected MAs to administer medications when they popped up on the eMAR to be administered. -If a medication popped up on the eMAR to be administered and it did not coincide with the instructions for administering the medication she expected the MA to verify the order with her. -She could change the days that Resident #1's clobetasol was administered on the eMAR but she did not think it could be entered to be administered 2 days on and 2 days off. -The MAs could document Resident #1's clobetasol as not administered on the off days on the eMAR but she had not instructed them to do so. Interview with the Administrator on 10/12/23 at 4:03pm revealed: -The facility's contracted pharmacy placed medication orders on the eMAR as well as times of administration. -The RCC could change the times and days on the eMAR for resident's medications.	D 358		

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D 358	Continued From page 12 -Resident #1's instructions for administration for her clobetasol were correct on the eMAR. -The MAs should have noticed the instructions for administration were different than what popped up on the eMAR and should have questioned the order with either the RCC, the pharmacy, or herself. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/12/23 at 3:07pm revealed: -The current order for Resident #1's clobetasol was to apply it to her arms twice a day 2 days on and 2 days off. -One tube of clobetasol was dispensed for Resident #1 on 10/02/23. -The pharmacy placed medication orders and times for administration on resident's eMARs. -The pharmacy did not place the correct days to administer Resident #1's clobetasol on the eMAR because even though it was dispensed on 10/02/23 they did not know when the facility would start administering it. -She was not sure if the facility could adjust the days that Resident #1's clobetasol was administered but if they contacted the pharmacy the pharmacy could adjust the days of administration on the eMAR. Attempted telephone interview with Resident #1's dermatologist on 10/12/23 at 3:17pm was unsuccessful.	D 358		
D 429	10A NCAC 13F .1106 (c) Settlement Of Cost Of Care 10A NCAC 13F .1106 Settlement Of Cost Of Care	D 429		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL042007	A. BUILDING: _____ B. WING _____	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF LAKE GASTON	206 NORTH MOSBY AVE LITTLETON, NC 27850

(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 429	Continued From page 13 (c) When there is an exception to the notice, as provided in Rule .0702(h) of this Subchapter, to protect the health or safety of the resident or others in the facility, the resident is only required to pay for any nights spent in the facility. A refund shall be made to the resident by the facility within 14 days from the date of notice. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure a refund was issued to 1 of 1 resident (#6) within 14 days of their discharge. The findings are: Review of Resident #6's Resident Register dated 08/30/22 revealed: -Resident #6 was admitted to the facility on 08/30/22. -Resident #6 was discharged from the facility on 01/06/23. -The resident was discharged due to the need for a skilled nursing facility. Review of the facility's Move-out/Room and Board Refund form dated 01/06/23 revealed: -The form was completed on 01/06/23. The refund was to be issued to the estate of Resident #6. -The refund to be issued was $3,774.19. Review of the refund check dated 10/12/23 revealed a check as made payable to Resident #6 in the amount of $3,774.19. Telephone interview with Resident #6's Power of	D 429		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 429	Continued From page 14 Attorney (POA) on 10/11/23 at 12:27pm revealed: -He was Resident #6's POA. -He had not received the reimbursement since his family member was discharged. -Resident #6 was discharged from the facility on 01/06/23 to a skilled nursing facility. -He made several phone calls to the Administrator since February 2023 regarding the refund and had not received a call back. Interview with the Business Office Manager on 10/12/23 at 4:4:02pm reveals: -She had spoken with Resident #6's POA in March 2023 or April 2023 regarding the refund. -The POA was informed that the refund information was submitted to the corporate office and was still being processed. -She completed an excel spreadsheet that would calculate if a refund was due to the resident. -The refund information was forwarded to the accounts payable department who was responsible for cutting the refund check. -She received the refund check for Resident #6 on 10/12/23 and the check was scheduled to be mailed overnight to the POA on today, 10/12/23. -The accounts payable department would sometimes send the refund check to the resident or their POA or the refund check would be forwarded to the facility's to be mailed to the resident or the POA. -The time to process refund payments was 1 to 2 weeks after the discharge of a resident. -She was the person responsible for processing all resident refund payments and sending to the corporate office accounts department for further processing. Interview with the Administrator on 10/12/23 at 3:44pm revealed: -Resident #6 was discharged on 01/06/23	D 429		

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D 429	Continued From page 15 because of the need for a more skilled nursing facility. -She had not spoken with Resident #6 POA about receiving a refund. -She replied to email on 02/01/23 from the Eastern Division Vice President of Operations noting that Resident #6 had not received her refund. -The corporate office accounts payable process all refund payments. -The refund payment for Resident #6 would be mailed to her POA on 10/12/23. -The BOM was responsible for processing refund payments and submitting to accounts payable.	D 429		