STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345541	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Health & Rehab Center	13825 Hunton Lane Huntersville, NC 28078

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006 Based on record reviews and staff interviews, the facility failed to check a finger-stick blood sugar (FSBS) for 1 of 6 residents reviewed for unnecessary medications (Resident #311). The findings included: Review of the hospital discharge summary dated 2/21/2024 revealed Resident #311 had an order for Metformin (anti-diabetic medication) 500 milligrams (mg) twice a day. There were no orders for finger-stick blood sugar (FSBS) checks. Resident #311 was admitted to the facility on [DATE] with multiple diagnoses which included surgical repair of right hip fracture, diabetes, and asthma. Documentation on the care plan initiated 2/21/2024 revealed Resident #311 had diabetes mellitus with interventions to assess, document, and report to physician signs and symptoms of hypoglycemia (low blood sugar) such as sweating, tremors, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, and staggered gait. A review of the facility admission orders dated 2/21/2024 revealed Resident #311 had orders for Metformin 500 mg twice a day. There were no orders for FSBS checks. A review of the facility's physician admission history and physical dated 2/23/2024 revealed Resident #311 was admitted to the facility following a fall with a right hip fracture with surgical repair. Resident #311 was noted to be a non-insulin dependent diabetic receiving Metformin twice a day. Review of an additional physician order dated 2/23/2024 revealed Resident #311 had an order to check FSBS every morning and at bedtime starting 2/24/2024 and to notify physician if blood sugar less than 70 or greater than 299 milligrams/deciliter (mg/dl). HgbA1C (blood test that measures person's average blood sugar level over the past 2-3 months) was also ordered for 2/26/2024. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #311 was moderately cognitively impaired, required set up for meals and was totally dependent for toileting, bathing, dressing, and transfers. The MDS also revealed Resident #311 was receiving hypoglycemic medications. A review of the Point-of-Care Blood Sugar Summary report for Resident #311 revealed that no FSBS was obtained on the morning of 2/24/2024. (continued on next page)

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) on 2/24/2024 revealed Resident #311 took all morning medications including Metformin as ordered by the physician. Review of the Medication Error Report dated 2/25/2024 revealed the physician had ordered FSBS to be obtained every AM and every PM for trending. Unit Manager (UM) #2 confirmed the order and did not add supplementary documentation so the order did not flow to the MAR and alert nursing to obtain the FSBS. An attempt to conduct a phone interview on 9/25/2024 with Nurse #3 was unsuccessful. Nurse #3 was assigned to Resident #311 on 2/24/2024. The phone number was no longer in service. A joint interview was conducted with the Administrator and the DON on 9/25/2024 at 2:34 PM. The DON stated that the order for Resident #311's FSBS did not contain the supplemental documentation so the order did not flow to the MAR which would have alerted the nursing staff to collect the FSBS. The Administrator stated that the facility had developed a robust educational plan which included demonstration of order entry with supplemental documentation that was required for all nursing staff. The facility provided the following corrective action plan with a completion date of 2/28/2024. Address how corrective actions will be accomplished for those residents to have been affected by the deficient practice: On 2/24/2024 the Director of Nursing became aware that the facility had failed to obtain a FSBS on the morning of 2/24/2024 as ordered by the physician for Resident #311. On 2/24/2024 the Director of Nursing audited Resident #311's chart and noted that on 2/23/2024, the physician entered orders for blood sugars to be obtained twice a day for monitoring starting the morning of 2/24/2024. The order was confirmed by UM #2, but she failed to ensure the supplemental documentation was ordered to ensure it fired out to the Medication Administration Record for the nurse to obtain the blood sugar as ordered. How will the facility identify other residents having the potential to be affected by the same deficient practice? On 2/25/2024 the Regional Director of Clinical Services completed an audit of all orders of residents who required blood sugar monitoring to ensure the supplemental documentation was in the order and that the blood sugars were being monitored per orders. One additional order was identified that supplemental documentation was missing for blood sugar and was corrected immediately. Resident noted with no adverse side effects. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? On 2/25/2024 the Director of Nursing educated all Licensed Nurses via demonstration on entering orders requiring supplemental documentation to include blood sugars and when confirming orders to ensure supplementary documentation is in place if indicated. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/2024 the Regional Director of Clinical Services verbally instructed and demonstrated entering orders requiring supplemental documentation with the Medical Director. This education is already embedded into the Orientation for Licensed Nurses. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? An AD HOC Quality Assurance Performance Improvement Plan meeting was held on 2/27/2024 to determine the root cause analysis of the deficient practice, put a plan of action in place to ensure all orders requiring supplemental documentation are reviewed for accuracy. The monitoring for the plan was initiated on 2/29/2024 and completed on 4/29/2024 with no revision needed and a 100% compliance was achieved. The results of the monitoring will be brought to the Quality Assurance Performance Improvement meeting for the next 3 months, ending May 2024. Quality Improvement Monitoring schedule will be modified based on the findings of monitoring. Alleged Date of Compliance: 2/28/2024. The facility's corrective action plan with correction date of 2/28/2024 was validated onsite by observations, record reviews, and interviews with the Administrator, DON, Medical Director, and nursing staff. An observation was conducted during a medication pass for a FSBS collection on 9/25/2024. The FSBS was collected according to physician's orders at the correct time of day utilizing appropriate infection control measures. The results were documented in the Electronic Medical Record (EMR) correctly and no follow-up action was required by nursing. Interviews with nursing staff including Licensed Practical Nurses, (LPN), and Registered Nurses (RN) confirmed they had received education related to FSBS, order entry including supplemental order documentation, and confirmation of the supplemental documentation. The nurses were able to describe the order entry process including documentation of supplemental orders and verbalized understanding of the education received. Review of audit records revealed all residents receiving FSBS were audited by the DON for 8 weeks beginning 2/25/2024. Then monthly for 1 month to ensure all orders for FSBS had supplemental documentation and were being performed as ordered by the physician. The findings were reported to the Administrator and to the Quality Assurance Performance Improvement Committee monthly for 3 months for suggestions and/or recommendations; the quality improvement monitoring schedule will be modified based on finding of the monitoring. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews with the Administrator, Regional Director of Clinical Services, and the DON revealed the facility launched an in-service related to FSBS and supplemental documentation immediately after the incident to re-educate all licensed nurses. The Director of Clinical Services and the DON audited the supplemental orders for FSBS to ensure all orders contained supplemental documentation. The Administrator, Regional Director of Clinical Services, and the DON stated the interventions were successful as the facility did not have any further issues with FSBS and supplemental documentation standards. The corrective action plans completion date of 2/28/24 was validated.