STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. BUILDING ______ B. WING ______	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN NORTH CAROLINA BAPTIST HOME	**213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806**

(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) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Infection Control Survey was conducted from 10/25/22 through 10/27/22. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 5VI211.	E 000		
F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted from 10/25/22 through 10/27/22. Event ID# 5VI211. The following intakes were investigated: NC00190745, NC00190774, NC00192016, NC00190268, and NC00189714. One of the 20 complaint allegations was substantiated but did not result in a deficiency.	F 000		
F 580 SS=B	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		11/17/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/17/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, the facility failed to notify the Responsible Party (RP) of a medication error when first identified for 1 of 1 sampled residents reviewed (Resident #1). Findings included:	F 580	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of	

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F 580

Continued From page 2

Resident #1 was admitted to the facility on 02/24/22 with diagnoses that included diabetes.

Review of Resident #1's medical record revealed a physician's order dated 06/17/22 for Basaglar Kwikpen Insulin (medication to treat diabetes) 100 unit/milliliter (ml) - inject 22 units subcutaneously (under the skin) at 8:00 PM.

The quarterly Minimum Data Set (MDS) dated 08/26/22 assessed Resident #1 with moderately impaired cognition. She received insulin injections 7 of 7 days during the MDS assessment period.

During a telephone interview on 10/26/22 at 4:19 PM, Resident #1's RP confirmed he was not notified until 08/09/22 that Resident #1 was administered an extra dose of insulin on 08/07/22.

During a telephone interview on 10/26/22 at 9:06 AM, the former Nurse Supervisor #1 confirmed she worked the evening of 08/07/22 during the hours of 3:00 PM to 11:00 PM when Resident #1 was administered an extra dose of insulin. Nurse Supervisor #1 explained she was trying to be helpful and assist Med Aide (MA) #1 and Nurse #1 with administering the insulin injections for the MA's assigned hall. Nurse Supervisor #1 recalled MA #1 administered Resident #1's oral medications at the same time Nurse Supervisor #1 had administered her insulin injection. Nurse Supervisor #1 stated when she went back to document the insulin administration, it had already been marked on the Medication Administration Record (MAR) as administered. Nurse Supervisor #1 explained she couldn't tell

F 580

Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.
Corrective Action:
Family was notified of Med Error that occurred on 8/7/2022, on 8/9/2022
Identification of other residents who may be involved with this practice:
All current residents have the potential to be affected by the alleged practice. On 10/28/2022 an audit was completed by the Director of Nurses and Director of Clinical Services that reviewed all Medication Administration Records for med errors.
No other medication errors were found.
Systemic Changes:
On 10/31/2022 the Director of Nurses and Administrator began in-servicing the nurses, medication aides, and medication techs (Full time, Part time, Per Diem, and agency) on the timeliness of notifying the resident representative if there is a med error.
The education focused on: A facility must immediately inform the resident; consult with the resident's physician and notify; consistent with his or her authority, the resident representative when there is a med error.
This in-service was completed by 11/17/2022. Any nurse, medication aide, or medication tech (full time, part time, Per Diem and agency) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the

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F 580	Continued From page 3 who documented it on the MAR because it only indicated "agency" and since both MA #1 and Nurse #1 were agency staff, she assumed MA #1 had accidentally checked off the insulin order on Resident #1's MAR when she had checked off the other medications that were administered to Resident #1. Nurse Supervisor #1 stated she was unaware that Resident #1 had received an extra dose of insulin the evening of 08/07/22 until she was notified by the Director of Nursing (DON) on 08/08/22. During an interview on 10/26/22 at 3:15 PM, Nurse #1 confirmed she worked the evening of 08/07/22 and was asked by MA #1 to administer Resident #1's insulin. Nurse #1 stated Nurse Supervisor #1 did not communicate with her that she would be administering the insulin injections for MA #1, so she looked at Resident #1's physician order, administered the insulin and then documented the administration on Resident #1's MAR as completed. Nurse #1 stated on the morning of 08/08/22 when Resident #1 appeared more lethargic than normal, she took Resident #1 to the DON's office and explained she might have received an extra dose of insulin the evening of 08/07/22. Nurse #1 recalled the DON told her she would handle things from there. During an interview on 10/27/22 at 1:39 PM, the DON explained on the evening of 08/07/22 there was a lack of communication between Nurse Supervisor #1 and Nurse #1 as to who would administer insulin injections for the assigned Med Aide and as a result, Resident #1 received an extra dose of insulin. The DON recalled it was after the clinical meeting the morning of 08/08/22, sometime between 10:00 AM and 11:00 AM, when Nurse #1 brought Resident #1 to her office	F 580	standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing or designee, will review 5 residents each week to ensure there were no med errors, and if there was a med error, that it was reported timely to all parties. This will be done on a weekly basis, to include the weekend, for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Administrator to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality Assurance Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Staff Development Coordinator Nurse, Registered Nurse Supervisor, Dietary Manager, Social Worker, Rehab Director, and Dietary Manager. Date of Compliance: 11/17/2022	

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F 580	Continued From page 4	F 580		

stating she appeared lethargic and it was possible she had received an extra dose of insulin the previous evening on 08/07/22. The DON explained after speaking to both Nurse Supervisor #1 and Nurse #1, she discovered they had both administered insulin injections to Resident #1 the evening of 08/07/22 and Resident #1 was immediately assessed by the Nurse Practitioner who noted no negative outcome. The DON explained since Nurse Supervisor #1 and Nurse #1 had not realized a medication error had occurred on 08/07/22, she asked Nurse Supervisor #2 to call Resident #1's RP on 08/08/22 to inform him of the medication error. The DON stated the next morning (08/09/22) during the clinical meeting, she found out no one had contacted Resident #1's RP. The DON confirmed she personally notified Resident #1's RP on 08/09/22 at 1:00 PM of the medication error that occurred the evening of 08/07/22 and stated Resident #1's RP should have been notified of the medication error when it was first identified on 08/08/22.

A Grievance form dated 08/09/22 completed by the Director of Nursing (DON) on behalf of Resident #1's RP revealed a medication error occurred when Resident #1 received an extra dose of insulin on 08/07/22 and Resident #1's RP was not notified of the medication error until 08/09/22 by the DON.

During an interview on 10/27/22 at 11:14 AM, the Administrator stated he would have expected for the nursing staff to have notified Resident #1's RP when the medication error was first identified.