STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	R-C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777 County: Mitchell

(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 and the Mitchell County Department of Social Services (DSS) conducted a follow-up and complaint investigation survey on July 07, 2015 through July 09, 2015. The complaint investigation was initiated by the Mitchell County DSS on June 26, 2015.	{D 000}	Responses to the cited Deficiencies do not constitute An admission or agreement By the facility of the truth of The facts alleged or Conclusions set forth in The statement of Deficiencies or corrective Action Report: The plan Is prepared solely as a Matter of compliance With State Law.	
{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 B VIOLATION Based on these findings, the previous Type B Violation was abated. Non-compliance continues. Based on record review and interviews, the facility failed to administer medications as ordered for 1 of 1 resident with orders for sliding scale insulin. (Resident #5). The findings are: Review of Resident #5's FL2 dated 05/15/15 revealed: - Diagnosis that included uncontrolled diabetes Type II. - Orders for Lantus, 15 units twice a day. (Lantus	{D 358}	1. Resident # 5 had her Diabetic Management orders changed 7/28/2015 per MD prescribed Diabetic protocol. All current Medication Technicians Have been trained by an RN on Diabetic and Insulin management. Including reading a sliding scale And calculations for administering Correct dosage.	

POC accepted 8/14/15
Rita Wilson RN

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{D 358}	Continued From page 1 is an insulin used to lower blood glucose.) Review of an endocrinology consult dated 06/19/15 revealed the following orders: - Lantus 25 units at bedtime. - Novolog 5 units at breakfast, lunch and supper. (Novolog is a fast acting insulin used to lower blood glucose.) - Blood glucose monitoring before meals and at bedtime. - Adjustments to Novolog sliding scale insulin (SSI), depending on results of blood glucose, included: if less than 50, delay injection until immediatley after the meal and reduce insulin by 4 units; if between 51-70, immediately eat and take injection just before eating and reduce insulin by 2 units; and if between 71-150, take prescribed dose of insulin. Further review of the endocrinology consult dated 06/19/15 revealed orders for additional Novolog insulin before each meal based on these parameters: - 151-200, add 1 unit. - 201-250, add 2 units. - 251-300, add 3 units. - 301-350, add 5 units. - 351-400, add 7 units. Review of Medication Administration Records (MARs) for June 2015 revealed: - Finger Stick Blood Sugar (FSBS) levels were scheduled for 7:00am, 11:30am and 5:00pm. - Beginning on 06/20/15, FSBS levels were recorded incorrectly 11 times out of 31 opportunities. Continued review of the June 2015 MAR revealed: - At 7:00am on 06/20/15 Resident #5's blood	{D 358}	2. All newly hired Medication Technicians will be trained on Understanding the sliding scale for Managing the diabetic resident's BS levels and for calculating correct dosage, before they are allowed to pass medication. Medication Technicians will be Required to complete the Diabetic Resident management, Including understanding the Sliding Scale and calculation Of correct dosage, semi-Annually.	

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{D 358}	Continued From page 2 sugar level was 43 and 6 units of Novolog insulin was recorded as given. Per SSI order 1 unit of Novolog was to be administered. - At 11:30am on 06/21/15 Resident #5's blood sugar level was 107 and 7 units of Novolog insulin was recorded as given. Per SSI order 5 units of Novolog was to be administered. - At 7:00am on 06/23/15 Resident #5's blood sugar level was 198 and 1 unit of Novolog insulin was recorded as given. Per SSI order 6 units of Novolog was to be administered. - At 11:30am on 06/23/15 Resident #5's blood sugar level was 398 and 5 units of Novolog insulin was recorded as given. Per SSI order 12 units of Novolog was to be administered. - At 5:00pm on 06/23/15 Resident #5's blood sugar level was 213 and 6 units of Novolog insulin was recorded as given. Per SSI order 7 units of Novolog was to be administered. - At 11:30am on 06/24/15 Resident #5's blood sugar level was 286 and 7 units of Novolog insulin was recorded as given. Per SSI order 8 units of Novolog was to be administered. - At 11:30am on 06/25/15 Resident #5's blood sugar level was 186 and 5 units of Novolog insulin was recorded as given. Per SSI order 6 units of Novolog was to be administered. - At 5:00pm on 06/26/15 Resident #5's blood sugar level was 54 and 0 units of Novolog insulin was recorded as given. Per SSI order 3 units of Novolog was to be administered. - At 5:00pm on 06/27/15 Resident #5's blood sugar level was 158 and 6 units of Novolog insulin was recorded as given. Per SSI order 6 units of Novolog was to be administered. - At 5:00pm on 06/28/15 Resident #5's blood sugar level was 74 and 0 units of Novolog insulin was recorded as given. Per SSI order 5 units of Novolog was to be administered. - At 11:30am on 06/29/15 Resident #5's blood	{D 358}	3. All new orders will be reviewed By the Resident Care Coordinator and faxed to the contracted pharmacy. The original physician's order will be placed in the resident record chart. A fax confirmation will be placed in the Physician Order binder kept in the RCC office. The RCC will verify the medication has Been received by the pharmacy And correctly placed on the MAR. The RCC Will then sign and date the Faxed Confirmation copy on the Physician Order. The verified Order copies will be kept for six Months.	

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{D 358}	Continued From page 3 sugar level was 303 and 8 units of Novolog insulin was recorded as given. Per SSI order 10 units of Novolog was to be administered. Review of MAR for July 2015 revealed: - FSBS levels were scheduled for 7:00am, 11:30am and 5:00pm. - FSBS levels were recorded as administered 18 times out of 18 opportunities. - There was a row recording the "site" of the injection. - There were no rows to record FSBS levels or number of insulin units administered. Telephone interview on 07/08/15 at 9:50am with a pharmacist of the facility's contracted pharmacy revealed: - The technician who had entered the information on the July 2015 MAR was a new employee and entered the information incorrectly. - The pharmacy had erred by not entering a row to record FSBS levels and a row to record the number of insulin units administered. - The pharmacist would immediately correct the MAR. Interview on 07/08/15 at 10:50am with Staff A, Medication Aide, revealed: - She was "pretty sure" she administered 6 units of Novolog insulin (1 unit was recorded as administered) to Resident #5 on 06/23/15 at 7:00am. - She "typed it in wrong". - She did remember asking about the 06/19/15 endocrinology consult order because she had "never had this kind of order for SSI". - She had reviewed the SSI order with the Resident Care Coordinator (RCC) and a "corporate staff" and understood the order. - She was sure she administered Resident #5's	{D 358}	4. The RCC will monitor daily Residents with orders for Insulin, to insure correct dosage is given. 5. New orders are reviewed at the Daily Stand up Meeting Monday Through Friday. 6. Medication Administration will Be reviewed monthly at the QA Meeting for six months and Thereafter if necessary.	8/21/15

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{D 358}	Continued From page 4 insulin correctly, she just "punched in the wrong numbers" for the incorrectly recorded insulin units at 11:30am on 06/23/15, 06/24/15, 06/25/15, 06/29/15 and at 5:00pm on 06/27/15. - She had asked the RCC about the changes to the July 2015 MAR. - She stated the RCC had said there was a new order and to record per what had been on the MAR. - She had been "writing down on shift notes or scrap pieces of paper" Resident #5's FSBS level and units administered. Review of Resident #5's July 2015 care notes revealed: - On 07/01/15, "FSBS at 10:50am 483". - On 07/02/15, "resident B/G was low this morning, gave juice and her B/G went up". - On 07/07/15, "374 BG at 3:56pm". Interview on 07/08/15 at 11:17am with Staff B, Medication Aide, revealed: - She primarily worked on the Special Care Unit. - She had not administered insulin to Resident #5 on 06/26/15 at 5:00pm because she "recalled being told by corporate not to administer when (FSBS levels) were low". - She had "checked (Resident #5's FSBS level) about one hour later and it was still low, I can't remember but it wasn't much higher than 54. - On 07/01/15 when Resident #5's FSBS level had been 483 at 10:50am she remembered the (Corporate Clinical Specialist) instructing her to administer 8 units of insulin (per SSI order 12 units was to be administered). - She had not recorded on the July 2015 MAR the number of units administered. - She had been "told to just record the site" on the July 2015 MAR but could not "remember who told her".	{D 358}		

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{D 358}	Continued From page 5 - "I'll be honest, it was a confusing order." - She had notified the RCC of Resident #5's 483 FSBS level and the RCC said they would notify the physician, "that is protocol". Interview on 07/08/15 at 2:10pm with Resident #5 revealed: - She knew she was being administered SSI. - She knew she received FSBS checks four times a day. - She did not know the specifics about the sliding scale order from the endocrinologist. - She did not recall any adverse effects following administration of her SSI. - Facility staff "takes care of her medications". Telephone interview on 07/08/15 at 2:37pm with the Corporate Clinical Specialist revealed: - She had been working at the facility "on and off for the last three weeks going through charts, solving problems and checked on residents". - She had instructed one of the staff to add columns on the July MAR to record Resident #5's FSBS level and insulin units administered. - "I showed them what it should look like, I can't tell you who I told, I don't know, it may have been the RCC." - She had not followed up to see if the changes had been made. Interview on 07/08/15 at 3:35pm with the Corporate Executive Director revealed: - She had known about Resident #5's SSI endocrinology consult order dated 06/19/15. - She had instructed the RCC to clarify the order. - She had not followed up with the RCC to see if the order had been clarified. - She would have expected the RCC to follow through on clarifying the order. - The RCC is no longer employed at the facility.	{D 358}		

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{D 358}	Continued From page 6 - Corporate staff have been auditing resident records and "we didn't check (Resident #5's July 2015) MAR, we just missed it". The facility provided documentation showing all medication aides had received an in-service training on insulin administration and sliding scale on 07/08/15. Further review of Resident #5's record revealed a physician's order dated 07/07/15 for: - Discontinue current FSBS. - Discontinue Novolog. - FSBS before meals at 6:30am, 11:30am and 4:30pm. - Novolog sliding scale three times daily for above sugars to be given right after meals at 7:30am, 12:30pm and 5:30pm. - 0-100, 0 units - 101-150, 5 units - 151-200, 6 units. - 201-250, 7 units. - 251-300, 8 units. - 301-350, 10 units. - 351-400, 12 units. - 401-450, 15 units. - 451 or more, 15 units and call the doctor. - For FSBS of 40-60 give one cup of orange juice and notify the doctor. - For FSBS of 60-80 give ½ cup orange juice. - For FSBS of less than 40 call Emergency Medical Services and notify the doctor. - Recheck in one week. Telephone interview on 07/09/15 with staff from the Endocrinologist's office revealed: - There was no way of knowing the impact to Resident (#5) due to the uncertainty about the accuracy of the charting on the (June 2015) MAR. - The doctor recommended no changes to	{D 358}		

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{D 358}	Continued From page 7 Resident #5's sliding scale order.	{D 358}		