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D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure 1 of 2 sampled medication aides (Staff D) had completed training on the care of the diabetic resident prior to the administration of insulin. The findings are: 1.Review of the employee record for Staff D revealed: -Staff D was hired on 6/9/2014 as a medication aide (MA).	D 164		

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-Staff D had completed the medication clinical skills checklist on 6/26/2014.
-Staff D had taken the state medication aide test on 6/7/2005.
-There was no documentation of training on the care of the diabetic resident in the record.

Review of the Medication Administration Records (MAR) for October, November and December 2015 revealed:
-Staff D had initialed the MAR's for having performed finger stick blood sugar checks.
-Staff D had initialed the MAR's for administration of insulin to 1 of 5 sampled residents.
-Staff D had initialed the MAR's for one resident during the observation of the medication pass.

[According to the Humalog manufacturer, the pen should be primed before each injection. A dose of 2 units should be dialed up and the injection button pressed until the dose window shows a "0" and a stream of insulin is seen coming from the needle. This removes air bubbles and ensures the pen and needle are working properly. (Air bubbles displace the amount of insulin in the syringe and prevents the full dose from being administered.)]

Observation on 12/9/2015 at 11:55 am of Staff D, MA during the lunch medication pass revealed:
-Staff D performed a finger stick blood sugar on a resident at 11:55 am and administered Humalog (Humalog is a rapid acting insulin that lowers blood sugar) 4 units subcutaneously to the resident at 12:00 pm as per physician's order.
-The MA did not prime the Humalog pen with a 2 unit air shot prior to dialing the 4 units ordered and administered the insulin.

Interview with Staff D on 12/9/2015 at 12:20 pm

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D 164	Continued From page 2 revealed she had never primed an insulin pen. Review of the staff schedule provided by the facility revealed Staff D had worked as a Medication Aide on 12/8/2015, 12/9/2015 and 12/10/15. Interview with the Assistant Health Services Director on 12/10/2015 at 12:50 pm revealed the Resident Director was responsible for maintaining staff records and required training. Interview with the Health Services Director on 12/10/2015 at 12:50 pm revealed: -There was a Registered Nurse that performed the training required for staff. -The facilities primary pharmacy performed some of the diabetes training to medication aides. -She was unsure when the last diabetes training was held. -She was not aware that a Medication Aide without diabetes training should not be administering insulin. Interview with a pharmacist at the facility's primary pharmacy on 12/9/2015 at 12:25 pm revealed: -She was unsure if the pharmacy performed any of the diabetic training for the facility. -Insulin pens were required to be primed prior to each dosage per manufacturer's instructions. -The information packet was provided in the insulin box that was delivered to the facility. Interview with a second pharmacist at the facilities primary pharmacy on 12/10/2015 at 8:30 am revealed the Humalog dispensed to the facility would have contained an information packet inside the box that stated the insulin pen should be primed prior to each insulin dose.	D 164		

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D 164	Continued From page 3 Interview with Staff D on 12/10/15 at 1:00 pm revealed she was unsure if she had taken any diabetic training.	D 164		
D 347	10A NCAC 13F .1002 (d) Medication Orders 10A NCAC 13F .1002 Medication Orders (d) Verbal orders for medications and treatments shall be: (1) countersigned by the prescribing practitioner within 15 days from the date the order is given; (2) signed or initialed and dated by the person receiving the order; and This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure verbal orders for medications for 2 of 5 sampled residents (#2 and #5) were countersigned by the prescribing practitioner within 15 days from the date of the order. The findings are: 1. Review of Resident #5's FL-2 dated 3/30/2015 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, hypercholesterolemia, depression, normal pressure hydrocephalus. Review of Licensed Health Professional Support (LHPS) review dated 10/15/2015 listed tasks for finger stick blood sugars and insulin administration. Review of Resident #5's physician orders revealed:	D 347		

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D 347	Continued From page 4 -A verbal order for Novolin N (insulin), give 60 units this morning dated 8/8/2015 with no provider's signature. -A verbal order for Novolin (insulin), give 10 extra units tonight dated 10/12/2015 with no provider's signature. -A verbal order for Novolin (insulin), give 10 extra units tonight dated 10/20/15 with no provider's signature. Review of Resident #5's August 2015 Medication Administration Record (MAR) revealed: -An entry in the "Nurse's Comment" section for 8/8/2015 at 9:24 am stating to give 60 units of Novolin N. -There was no documentation of Novolin N 60 units being administered. Review of Resident #5's October 2015 MAR revealed: -There was no documentation of the Novolin extra 10 units being administered per physician order on 10/12/15. -There was no documentation of the Novolin extra 10 units being administered per physician order on 10/20/15. Interview with the Assistant Health Services Director on 12/9/2015 at 11:45 am revealed: -She was responsible for all medication orders. -She performed all clarifications of orders. -She took responsibility and should have followed up on the orders that were not signed. -She would contact the primary care provider and obtain a signed copy of the verbal orders. Interview with the Health Services Director on 12/9/2015 at 12:50 pm revealed: -The Assistant Health Services Director was responsible for medication orders.	D 347		

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-If the Assistant Health Services Director was not available the Health Services Director would take responsbility.
-When a Medication Aide (MA) had to call the on call provider, the provider would give them a verbal order.
-The verbal order would be transcribed onto a physician's order sheet and then faxed to the pharmacy and to the primary care provider to obtain a signature.
-The order would be placed in a basket in the medication room and the Assistant Resident Director would follow up on obtaining a signature on the next business day.
-If the Assistant Health Services Director was not available, the Resident Director would follow up on the orders.
-The on call physician "does not comply well", he would not sign the orders and fax them back.
-Verbal orders should be followed up on until a signature was obtained.
-Physician's orders containing a one-time dosage should be documented on the MAR.

Interview with a pharmacist at the facilities primary pharmacy on 12/10/2015 at 8:30 am revealed:
-The facility was supposed to fax all medication orders to the pharmacy.
-Verbal orders faxed to the pharmacy would be entered into the Electronic Medication Administration Record (eMAR).
-The pharmacy did not follow up to ensure the primary care provider signed the verbal orders.
-One time dose orders were not put into the eMAR by the pharmacy.
-One time dosage orders should have been put in the eMAR by the Medication Aide.

Review of Resident #5's physician orders on

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12/10/15 revealed:
-The verbal orders for 5/20/2015, 8/8/2015, 10/12/15 and 10/20/2015 had been faxed to the facility from the primary care provider's office.
-The primary care provider had signed each order and dated them 12/10/15.

Interview with the Medical Assistant at the primary care provider's office on 12/14/15 at 3:35 pm revealed:
-There was an on-call physician group that handled calls for the primary care provider outside of normal business hours.
-The on-call physicians keep a record of all calls and verbal orders given and reported them back to the primary care provider.
-The facility should fax over a copy of the verbal order after it is received so that it may be signed by the provider.

2. Review of the current FL-2 dated 7/13/15 for Resident # 2 revealed
diagnoses of petit-mal seizures, history of stroke with right sided hemiparesis, transient ischemic attack, diabetes mellitus II, chronic anemia, hypertension, osteoporosis, peripheral neuropathy and hypothyroid.

A. Review of medication orders for Resident #2 revealed:
-A medication order was handwritten on 10/08/15 for Diflucan 150mg 1 every 72 hours for 3 doses.
-The order was signed by a facility medication aide as a verbal order from the hospice nurse.
-The order was not signed by a prescribing practitioner as of the date of the survey.

Interview on 12/10/15 at 11:20 am with the medication aide (MA) revealed:
-When the medication aide takes a verbal order,

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it should be faxed to the pharmacy to be filled.
-She was not aware the hospice nurse was not a prescribing practitioner.
-The MA was not aware verbal order for the Diflucan was not signed by a prescribing practitioner.
-The Assistant Director of Health Services was responsible for the orders and getting verbal orders signed.

B. Review of subsequent medication orders dated 7/26/15, provided to the facility by and signed by the hospice nurse and not signed by a prescribing practitioner included:
-"Patient unable to swallow [family member] requesting to have DC'd":
D/C (Discontinue) Calcium plus Vitamin D 500 mg daily. (Mineral supplement)
D/C Vitamin B12 100mcg 1 tablet daily (Vitamin supplement)
D/C Vitamin C 500mg 1 tablet daily (Vitamin supplement);
D/C Zinc Sulfate 200mg 1 cap daily. (Mineral supplement)
D/C Vitamin D3 2000 units 1 daily. (Vitamin Supplement)

Review of the medication administration records (MAR) for October 2015, November 2015 and December 2015 revealed the Calcium, Vitamin B12, Zinc, Vitamin D3 and Vitamin C were not on the MARs. for administration.

Review of Resident #2's medications on hand revealed there was no Calcium, Vitamin B12, Zinc, Vitamin D3 and Vitamin C for administration.

Interview on 12/10/15 at 11:20 am with the medication aide (MA) revealed:

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D 347	Continued From page 8 -Resident # 2 had not had these supplements for months. Around the summer time they were discontinued. -The resident had a swallowing problem with some medications and the hospice nurse discontinued them. -The MA was not aware only the hospice nurse had signed the discontinuation and that she was not a prescribing practitioner. -The MA did not know the order had not been signed by the nurse practitioner or physician. -The Assistant Director of Health Services was responsible for the orders to be signed. C. Review of hand written orders dated 9/10/15 provided to the facility and signed by the hospice nurse had not been signed by a prescribing practitioner included: -Discontinue tegaderm to sacrum. -Discontinue Flagyl, hydrogel to right 3rd, 4th, 5th, toes. -Cleanse sacrum with wound cleanser, apply hydrogel, 4 X 4 gauze, secure with border gauze as needed and 3 times /week. -Cleanse 3rd, 4th, and 5th toes with wound cleaner, apply Medihoney to toes to cover with telfa and secure with cling wrap; change 3 X per week and as needed. Review of the September 2015 medication administration record (MAR)revealed the wounds had been cleansed and dressed on the 7 a.m.- 3 p.m. shift on 9/11, 9/16, 9/121, 9/23, 9/25, and 9/30. Interview with the Assistant Health Services Director (AHSD) on 12/9/2015 at 11:45 am revealed: -She was responsible for all medication orders. -She performed all clarifications of orders.	D 347		

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D 347	Continued From page 9 -She took responsibility and should have followed up on the orders that were not signed. Interview on 12/09/15 at 11:55 am with the Health Services Director (HSD) revealed: -The hospice company for Resident #2 did not complete orders while in the facility. -The facility had to get the orders from the hospice nurse after they were signed. -The AHSD would follow up with orders needing signature. Interview on 12/09/15 at 12:45 pm with the hospice nurse revealed: -The physician / nurse practitioner was to sign the orders after the nurse had written them out. -The hand written orders would be given to the physician by the nurse to be signed. -The physician was to sign them and fax them to the facility. -She was not sure why they had not been signed and faxed to the facility in a timely manner. Interview with the HSD on 12/9/2015 at 12:50 pm revealed: -The AHSD was responsible for medication orders. -If the AHSD was not available the HSD would take responsibility. -When a Medication Aide (MA) had to call the on call provider, the provider would give them a verbal order. -The verbal order would be transcribed onto a physician's order sheet and then faxed to the pharmacy and to the primary care provider to obtain a signature. -The order would be placed in a basket in the medication room and the Assistant Resident Director would follow up on obtaining a signature on the next business day.	D 347		

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D 347	Continued From page 10 -If the AHSD was not available, the Resident Director would follow up on the orders. -Verbal orders should be followed up on until a signature was obtained.	D 347		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep	D 482		

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a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
Based on observation, interviews and record reviews, the facility failed to assure physical restraints were used only with a written order from a physician and used only after a team assessment and care planning process had been completed for 2 of 2 sampled residents (#1 and #6), used to prevent residents from falling out of bed. The findings are:

1. Review of the current FL-2 for Resident #2 revealed:
-Petit-mal seizures, history of stroke with right sided hemiparesis, transient ischemic accidents, Diabetes Mellitus Type II, chronic anemia, hypertension, osteoporosis, peripheral neuropathy and hypothyroid.
- There was no information on the current FL-2 related to the use of bedrails.

Review of the Assessment and Care Plan dated 8/19/15 included:
-The resident was total care for activities of daily living.

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D 482	Continued From page 12 -There was no documention related to the use and care of the resident with bed rails up while in the bed. Review of the record for Resident #2 revealed: -An order dated 2/23/15 for an electronic hospital bed with 1/2 bed rails due to diagnoses of transient ischemia in the brain was in the record. -There was no physician order related to use of the bed rails as restraints. Review of the record for Resident #2 did not reveal any documentation related to bed rail use to keep the resident from falling out of the bed. Review of the last two quarterly Licensed Health Professional Support Reviews (LHPS) reviews dated 8/17/15 and 11/03/15 revealed there was no documentation of the 1/2 bed rails as restraints or as enablers. Observation on 12/08/15 at 12:50 pm of Resident #2 revealed: -The resident was asleep and sitting in bed in semi-fowlers position with bilateral 1/2 bed rails in the up position. -The bed was raised to a high position. Interview on 12/08/15 at 1:12 pm with a medication aide (MA) revealed: -Resident #2 could communicate verbally and have conversation. -The resident was a hospice resident and received total care with activities of daily living. -The resident required turning every 2 hours since the resident had sores on the buttock area. -The resident required emptying of the Foley catheter every 2 hours. -The resident needed to be fed and was a good eater.	D 482		

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-The resident could move in the bed and turn by herself with the help of the bed rails in the up position.
-The resident could not get out of the bed to stand alone.
-Resident # 2 could get her legs over the side of the bed, however.
-The bedrails in the up position were for the resident's safety to prevent falls out of the bed.
-The resident had not had any falls in the facility.

Interview on 12/09/15 at 9:40 am with a personal care aide revealed:
-Resident #2 had the hospital bed with the bed rails in use so the resident would not roll off the bed.
-The resident gets right to the edge of the bed by herself.

A second interview on 12/09/15 at 1:15 p.m. with the first MA revealed:
-The bedrails in the up position were used to keep Resident #2 in the bed.
-The bed rails had been used to protect the resident since the order of the hospital bed months ago.
-The resident was more mobile and able to move than perhaps thought.
-The resident had been seen to scoot to the bottom of the bed at the foot board.
-The resident had never gone over the foot board.
-The resident would move right up to the bed rails and the edge of the bed on each side.
-The resident had not gone off of the side of the bed.
-The MA had to protect the resident from the bed rails that were up with pillows because the resident would get her face right up against the rails.
-The bed was in a high position and the MA did

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	HAL092017	A. BUILDING: _____ B. WING _____	12/10/2015

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D 482	Continued From page 14 not know how low it would go down towards the floor. -The MA was not aware of any alternatives used instead of the bed rails to prevent the resident from falling. -The MA was not aware of an order for the use of the bedrails to protect the resident but the bed with the rails had been ordered by hospice. Observation of Resident #2 on 12/09/15 at 9:10 am revealed: -Bilateral 1/2 bed rails were in the up position. -The bed was in the high position. -The resident was in semi-fowlers position with pillows under the knees and pillows against each bed rail next to the resident. Interview on 12/09/15 at 11:30 am with the Director of Health Services (DHS) revealed: -The facility was,"restraint free." -Bed rails in the facility were enablers, not restraints. -The DHS thought Resident # 2's bedrails were used as enablers previously, but not used so much now as the resident did not move much in the bed anymore. -Staff had not informed her of the use of bedrails for safety to prevent falls due to the resident's ability to move. - There had not been an assessment and care plan completed for the use of the bed rails for Resident #2. Interview on 12/09/15 at 12:45 p.m. with the hospice nurse revealed: -Resident #2 could move around a small amount in the bed. -The bedrails were used as an enable for her while turning for dressing changes, but not as restraints.	D 482		

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D 482	Continued From page 15	D 482		

-The resident could turn slightly herself and hold the rail even with her contracted right hand.
-The resident could not get out of the bed herself.
-The hospice nurse was not aware the bed rails were used by staff to prevent falling out of the bed.
-She was not aware of any assessment and care planning or orders for the use of bedrails as restraints.
-The hospice nurse was getting an order for a fall mat for the floor next to the resident's bed today.

Refer to telephone inteview on 12/10/15 at 12:31 pm with the facility's LHPS review nurse.

2. Review of the current FL-2 dated 7/13/15 for Resident #6 revealed:
-Diagnoses of dementia with behavior disturbance, anemia, atrial fibrillation, osteoporosis, transient ischemic attacks/ stroke, and previous lower leg fracture.
-Resident #6 was listed as intermittently disoriented and semi-ambulatory.
-The resident was admitted on 7/17/15.

Review of the Assessment and Care Plan dated 7/20/15 included:
-The resident was total care for activities of daily living except eating -extensive assistance.
-There was no documention related to the use and care of the resident with bed rails up while in the bed.

Review of Resident #6's record revealed:
-An order dated 8/04/15 for evaluation and treatment with hospice.
-An order dated 9/03/15 was for a floor mat for debility, fall risk and gait dysfunction.

Review of hospice notes dated 12/08/15 revealed

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D 482	Continued From page 16 the resident was totally dependent, non-ambulatory, had confusion, impaired judgement and was a fall risk. Review of the last two quarterly Licensed Health Support (LHPS) reviews dated 8/17/15 and 11/03/15 revealed there was no documention of the 1/2 bed rails as restraints or enablers. Observation on 12/08/15 at 12:59 pm of Resident #6 revealed: -The resident was asleep in the bed. -The bed was in a low position. -Bilateral 1/2 bed rails were in the up position. -A floor matt was next to the bed on the floor. Interview on 12/08/15 at 1:16 pm with a medication aide revealed: -Resident #6 was total care for activities of daily living. -The resident was transferred to a wheelchair during the day and taken out to the other areas of the facility. Observation of Resident #6's bed on 12/09/15 at 9:10 am with the Director of Health Services (DHS) revealed the resident had a hospital bed with bed rails and a mat on the floor. Observation on 12/10/15 at 8:45 a.m. revealed: -The resident was in bed asleep with the 1/2 bed rails in the up position. -The bed was in a low posiotion. -The fall mat was on the floor next to the bed. Interview on 12/09/15 at 9:15 a.m. with the DHS revealed: - The resident had a hospital bed with bed rails ordered by hospice. - The bed rails were used to so the resident	D 482		

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D 482	Continued From page 17	D 482		

would not fall out of the bed.
- The mat on the floor was to prevent injury if the resident got out of the bed.
- The DHS was not aware of any falls with the resident.

Interview on 12/09/15 at 9:40 am with a personal care aide revealed:
-Resident #6 had bed rails on the bed and a mat on the floor because the resident could get out of the bed.
-The bed rails were on the bed to protect the resident from falling.
- The resident had no known falls but could fall if the resident got up out of the bed.

Interview on 12/09/15 at 11:30 am with the Director of Health Services (DHS) revealed:
-The facility was "restraint free."
- Bed rails in the facility were enablers.
-The DHS thought Resident #6's bedrails were used as enablers.
-She was not aware the resident could move in the bed and get out and have a possible fall.
-There had not been a team assessment and care plan completed nor restraint orders nor responsible person consent for the use of the bed rails with Resident #6.

Refer to telephone nteview on 12/10/15 at 12:31 pm with the facility Licensed Health Professional Support review nurse.

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Telephone Inteview on 12/10/15 at 12:31 pm with the facility Licensed Health Professional Support (LHPS) review nurse revealed:
-The nurse completes the LHPS reviews quarterly for residents with tasks in the facility.

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D 482	Continued From page 18 -The nurse was not aware of any restraints in the facility but had noted bed rails on some of the beds. -The nurse thought 1/2 bed rails were not restraints. -The full bed rails provided no way to get out of the bed so they were considered restraints. -Resident #2 and #6 did not move much in the bed any more. -The nurse had not been asked by the facility to participate in a team assessment and care planning for any residents with bed rails in the facility. -She would review residents with bed rails to assess for restraints.	D 482		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on observation, interview and record	D934		

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D934	Continued From page 19	D934		

review, the facility failed to assure the state mandatory, annual in-service training program for adult care home medication aides on infection control had been completed for 1 of 2 sampled medication aides (Staff A). The findings are:

1.Review of the staff record for Staff A revealed:
-Staff A was hired on 3/22/2012 as a certified nursing assistant.
-There was documentation of passing the state medication administration test on 12/20/2012.
-Staff A was promoted to a medication aide and completed the medication skills checklist on 6/25/2013.
-Staff A had documentation of the state mandatory annual infection prevention training on 4/15/2013 and 4/22/2014.
-There was no documentation of completing the state mandatory annual infection prevention training in 2015.

Staff A was not available for interview.

Interview with the Assistant Health Services Director on 12/10/2015 at 12:50 pm revealed the Resident Director was responsible for maintaining staff records and required training.

Interview with the Health Services Director on 12/10/2015 at 12:50 pm revealed:
-There was a Registered Nurse that performed some of the trainings required for all staff.
-The facilities primary pharmacy performed some of the training to medication aides.
-She was in the process of getting everyone scheduled for the state mandatory annual infection prevention training.
-She was aware infection prevention training was required yearly for medication aides.
-She had scheduled Staff A to take the infection

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D934	Continued From page 20 prevention training in December 2015. -Staff A had not had the infection prevention training since 4/22/2014.	D934		