STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031017	A. BUILDING: _____ B. WING _____	R 10/28/2016

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D 000	Initial Comments The Adult Care Licensure Section and the Duplin County Department of Social Services conducted an annual and follow-up survey on October 26-28, 2016.	D 000		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure residents were served meals on non-disposable dishes, as observed during the lunch and dinner meal on 10/27/16. Observation of the assisted living dining room during the lunch meal on 10/27/16 at 12:30pm revealed: -Forty seven residents were seated in the dining room for the lunch meal. -The last 2 residents were served were served on paper plates. Interview with the dietary manager on 10/27/16 at 12:50pm revealed: She was aware residents were not to be served on paper products. -She had a do not use sign on the paper products	D 287		

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in the storage room, they were there for emergency purposes only.
-The 2 residents were served on paper plates because the facility ran out of plates.
-There were residents in the memory care dining room that requested more food and used extra plates, which caused them to run out of plates.

Observation of the assisted living dining room during the dinner meal on 10/27/16 at 5:30pm revealed a resident was served cereal in an individual prepackaged plastic container.

Confidential interviews with 4 residents revealed:
-Residents had been served meals on paper plates several times prior to the hurricane in October 2016.
-Residents were inconsistently served on non-disposable dishes.
-Sometimes some residents would be served meals on paper plates, while others would receive their meal on a paper plate.
-There was a time when the dish machine was broken and all of the residents received all of their meals on paper plates, with plastic utensils as well.
- " Thinks they get served on paper plates, because the kitchen regularly run out of regular plates. "

Interview with the Administrator on 10/27/16 at 11:00am revealed:
-She was aware residents were not to be served on paper products.
-She was not aware residents were being served meals on disposable dishes.
-Yesterday (10/27/16) after the lunch meal the dietary manager shared with her the kitchen was short 1 plate and a resident was served on a paper plate.

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D 287	Continued From page 2 -She directed the dietary manager to call the vender as soon as possible and order more plates. It usually would take twenty-four hours to receive the order. -The only other instances she was aware paper plates were used were during the hurricane 10/7/16 through 10/13/16, and 2 weeks prior to the storm the dish washer was broken and they used paper for 1 week while the motor was being replaced. She would ensure all of the kitchen staff were re-trained on the nutrition and food rules, including the rule that required residents to be served on non- disposable table settings.	D 287		
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: Based on observations, interview, and record review, the facility failed to assure medications were administered as ordered for 1 of 5 sampled residents (Resident #2), with orders for Humalog insulin. The findings are: Review of Resident #2's current FL-2 dated 10/20/16 revealed: - Diagnoses included Type II diabetes with hypoglycemia, hyperglycemia, hepititis C.	D 358		

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D 358	Continued From page 3 - The resident was intermittently disoriented, semi-ambulatory (used a cane), and needed assistance with bathing and dressing. Review of Resident #2's physician's orders dated 10/24/16 revealed: Humalog check finger stick blood sugars before meals and at bedtime with SSI (sliding scale insulin) as follows: < 250 = 0 units, 250-300 = 2 units, 301-350 = 4 units, 351-400 = 6 units, 401-450 = 8 units. Observation of the medication pass on 10/26/16 revealed: - At 3:42 pm the MA pricked the resident's finger, obtained the blood sample with a test strip, and placed the strip into the glucometer for the reading. - The blood sugar reading was 311. - The MA drew up 7 units (4+3) of Humalog and administered the insulin into the resident's right upper arm at 3:45 pm. Interview on 10/26/16 at 3:45 pm with the Medication Aide revealed: - She worked part-time at the faciliy administering medications to residents. - When the medication orders "popped up" on the e-MARS screen, it was time to administer the medicaion. - For Resident #2, the e-MARS popped up at 3:30 pm for the 4:30 pm administration; there was a 1 hr. window for administering medications. - The MA stated Resident #2 had an order for Humalog SSI (sliding scale insulin) and was to receive 4 units of insulin according to the order. - The resident also had an order for Humalog insulin 3 units before meals. - The time the insulin was administered to Resident #2 was within the time allowed. - The insulin was to be administered for the	D 358		

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evening meal.
- Dinner was served at 4:30 pm.
- The MA usually administered medications when they "popped up"; she did not usually read the order, she was in the habit of just looking for the "pop-ups".

Observation on 10/26/16 at 3:50 pm of the RCD and MA revealed;
- The RCD was standing at the nurse's station, across from the medication cart, observing the MA, and asked the MA if insulin had just been administered to Resident #2.
- The RCD told the MA the evening meal was served at 5:30 pm; the insulin was administered too early.
- The RCD reached for the telephone and called dietary and requested to immediately prepare Resident #2 a sandwich.

Interview on 10/26/16 at 4:20 pm with the RCD revealed:
- A ham and cheese sandwich was taken to Resident #2 at 4:00 pm.
- The resident ate all of the sandwich.

Observation on 10/26/16 at 5:08 pm of the resident dining room revealed residents were lining up and going into the dining room for dinner to be served at 5:30 pm.

Review of Resident #2's e-MARS for 10/26/16 revealed the resident had a blood sugar reading of 318 at the 8:00 pm medication pass and was administered 4 units of Humalog per sliding scale order.

Interview on 10/28/16 at 9:45 am with Resident #2 revealed:
- The resident was lying on his bed resting and

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said he was feeling "ok".
- Staff did finger stick blood sugar checks 3-4 times a day and he received insulin just about every time.
- He had insulin this morning, ate breakfast just afterward (did not remember the times).
- He went to the hospital about 3 weeks ago for low blood sugar; he felt dizzy and weak, "got it settled" and came back to the facility (did not remember the dates).
- He could not usually tell when his blood sugar went up or down.
- Staff administered his insulin; he thought they were following the doctor's orders.
- He felt better when he had his insulin.
- The resident was offered and ate a snack in the afternoons around 2:00 pm or a little later; he usually chose grapes or a banana, and a fruit bar, sometimes a bag of (chips) and water.
- He was given a ham and cheese sandwich after receiving insulin a day ago, but did not remember the time.
- He also went to dinner later when other residents lined up outside the dining room (did not remember the time).

Interview on 10/28/16 at 10:00 with 2 Personal Care Aides (PCA) revealed:
- The PCAs were taking the morning snacks down the hall on a cart to deliver to residents.
- Resident #2 usually ate his snacks and most often chose a banana, grapes, or strawberries and a fruit and grain bar; sometimes a bag of chips, water or lemonade.

Interview on 10/28/16 at 10:25 am with Resident #2's Power of Attorney (POA) revealed:
- The resident had been at the facility for 2 years and was satisfied with his care overall.
- The POA visited the resident about 3 weeks ago

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and he looked good.
- The resident had finger sticks and received insulin; he had diabetes, his pancreas had problems.
- His blood sugar gets "up" sometimes and staff would let the POA know; it was done correctly as far as she knew.
- Staff had not ever called to say they made a mistake with his insulin.

Review of Medication Error Report For Resident #2 revealed:
- The report was completed by the RCD.
- On 10/26/16 at 3:42 pm, "resident was supposed to be given insulin at meal times, Evening administration meal time was entered by (pharmacy) at 4:30 pm. Medication pop(ed) one hour before administration time which was 2 hours ahead for 5:30 pm meal times, resident was given (a) sandwich".
- Physician notified.
- Action to be taken: continue to monitor BS (blood sugar), check FSBS (finger stick blood sugar) and administer insulin within 15 minutes of mealtimes, NP will f/u (follow-up) with resident again on 10/31/16.

Interview on 10/28/16 at 11:40 am with the facility Pharmacy representative revealed:
- All facilities have different meal times, 4:30 pm (dinner) was the average meal time the Pharmacy used for medication administration.
- For a 4:30 pm medication administration, a window would "pop up" on the e-MARS computer screen at 3:30 pm.
- When orders were entered in the computer, facility MA'swere to review the order and accept, decline, or change the times for administration to "pop".
- For Resident #2, the 4:30 pm insulin order

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"popped" on the computer screen at 3:30 pm.
- Just because the order "pops" at a certain time does not mean staff should not read the order.
- Staff could have changed the time for the specific time to "pop" according to physician order.

Review of Resident #2's facility Incident/Unusual Occurrance Reports revealed:
- On 9/27/16 at 5:15 am the resident was found lying on his bed on his back and was unresponsive; his blood sugar was 38; the resident was sent by EMS to the local hospital and was admitted for low blood sugar and discharged the same day with an order fo Lantus 10 units at bedtime, Humalog 3 units 3 times/day with meals, sliding scale same.
- On 10/17/16 at 12:05 pm the resident was observed in the dining room seated at a table sweating, with cool and clammy skin; his blood sugar was 44; the resident was sent by EMS to the local hospital and admitted for low blood sugar,and was discharged the next day to the facility, no medication changes were documented on the e-MARS.

Interview on 10/28/16 at 10:45 am with the Nurse Practioner (NP) for the facility physician revealed:
- On 10/26/16 she was notified by the RCD that Resident #2 received his insulin early and was concerned about the timing of insulin administration prior to his evening meal and that he was given a sandwich to eat after the insulin administration.
- The NP came in the next morning 10/27/16) to assess the resident.
- Resident #2 had chronic pancreatitis (long-term inflammation of the pancreas that impairs the body's ability to digest food and regulates blood sugar) and dietary issues.

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- Sometimes the resident's blood sugar would be high as 500 (hyperglycemia), or low and have hypoglycemia.
- The resident had been hospitalized previously for hypoglycemia and had been managed by an Endocrinologist.
- Resident #2 had current orders for Humalog insulin to be used on a sliding scale and routine scheduled insulin before the evening meal.
- The order should have been clarified when ordered, but was clarified yesterday, 10/27/16, by the RCD.
- The NP had concerns about the resident's safety and medication error with Resident #2 having 3 insulin orders (Lantus 10 units a day, Humalog SSI (sliding scale insulin), and Humalog 3 units, 3 times a day.
- The NP's expectation was for staff to administer the insulin as close to the meal as possible, 15 minutes, or he could become hypoglycemic.

Review of the facility's Medication Policy and Procedures revealed:
- "Policy: Medication Management - It is the policy of (the facility) that medication administration will be accomplished according to physician orders, proper procedures and in response to resident needs. Medication administration staff will be required to read and practice medication policy and procedures."

Interview on 10/28/16 at 1:15 pm with the Resident Care Director (RCD) revealed:
- New medication orders are placed ina folder, the MA takes the orders and faxes them to the Pharmacy.
- The Pharmacy makes the order entry into the computer program.
- The times the medication is to be administered

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is entered by the Pharmacy.
- Medications have a 1-hr. window for administration, example an 8:00 am medication would be entered as 7:00 am.
- The entered time would be the "pop-up" time on the computer screen.
- When the MA saw the order on the computer screen, the MA can choose to accept or decline the entry.
- On 10/26/16, the Pharmacy had the insulin sliding scale and the scheduled insulin for (Resident #2) to be administered at 4:30 pm, so it was set to "pop-up" at 3:30 pm.
- " For (Resident #2), insulin time was set 2 hours early for dinner at 5:30 pm; he received his insulin 2 hours early."
- The RCD observed the medication pass and realized there was a problem and immediately ordered the resident a ham and cheese sandwich to eat.
- The resident had dinner at 5:30 pm.
- The facility Nurse Practioner (NP) was called after the sandwich was ordered to inform her Resident #2 received both the SSI insulin and scheduled insulin too early before the meal.
- The NP told the RCD Resident #2 would be followed-up and assessed in the morning.
- The next day, 10/27/16, the NP changed the SSI order to be administered 15 minutes prior to a meal and discontinued the routine insulin order.
- The RCD did not know why the MA administered Resident #2's insulin at that time, she should have questioned administering insulin that early before his meal, the "pop-up" time should have given her a mental red flag to check the order.
- The facility had a Medication Policy; the policy was not followed.

Interview on 10/28/16 at 2:05 pm with the

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D 358	Continued From page 10 Administrator revealed: - Before administering medication to residents, Medication Aides (MA) received 15 hours of training which included diabetes and insulin administration. - Insulin orders were to be read and verified to see if the order had all the information related to resident, dose, route and time to be administered. - When the facility Nurse Practicioner left new orders for residents, the MA or Supervisor sent the orders to the Pharmacy. - The Pharmacy would enter the order into the computer (e-MARS). - The computer organized physician orders for each resident as to times for medications to be administered. - When the insulin order for Resident #2 popped up on the computer screen, the MA should have read the order before administering the insulin. - People (staff) get conditioned to look at the pop-up window times; the MA did not look at the medication order instructions. - She did not follow the physician's order for the time to administer insulin for Resident #2 before meals. - The facility policy on medication administration was not followed.	D 358		