Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026008	A. BUILDING: _____ B. WING _____	12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE MILLS RETIREMENT CENTER	4217 ELK ROAD HOPE MILLS, NC 28348

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on December 6-7, 2016.	D 000		12/16/16
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record review the facility failed to assure follow up blood pressure results were reported according to parameters provided by the licensed practitioner to meet the routine and acute health care needs for 1 of 3 residents (#3) sampled. The findings are: Review of Resident #3's current FL-2 dated 09/26/16 revealed: -The resident's diagnoses included diabetes mellitus and diabetic neuropathy. -There was an order to check blood pressure daily and notify the physician for a systolic blood pressure greater than 170 or less than 100 or a diastolic blood pressure greater than 95 or less than 50. (The systolic blood pressure is the top number of a blood pressure reading, the diastolic blood pressure is the bottom number of a blood pressure reading). Review of Resident #3's October, November and December 2016 medication record review (MAR) revealed: -There was an entry to check blood pressures once daily. Notify the physician for systolic blood pressures greater than 170 or less than 100.	D 273	All residents physicians will be notified of all out of range blood pressure readings per orders. To assure this will be done, changes have been made to the residents blood pressure log form. Parameters are now printed on the form also a column has been added "MD notified." A sticky note is attached * with spaces for name, BP, date and Dr called. The aides have been instructed to document out of range blood pressures on log and sticky note. After that med pass the Med aide is to hand note directly to administrator or manager. The administrator or manager will be responsible for notifying physician of that	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Dona Sandy - administrator (X6) DATE

Kaitlen Hoard — facility manager — 1/2/17

* see att'd page - 1A

Reviewed & Accepted 1/9/2017 Wedwards

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D 273	Continued From page 1 Notify the physician for diastolic blood pressures greater than 95 or less than 50. -Blood pressure checks were scheduled to be performed at 9:00 a.m. -The Medication Aides (MA) documented initials daily that the blood pressures were checked. -There were no blood pressure results recorded. -There was an attached blood pressure log for each month. Review of Resident #3's daily blood pressure log for October 2016 revealed: -The blood pressures were recorded daily with a date, time, and MA signature. -The blood pressure parameters to notify the physician were not transcribed on the log. -The systolic blood pressure ranged from 95-178 from 10/01/16-10/31/16. -The systolic blood pressure was documented greater than 170 on 1 occasion. -The systolic blood pressure was documented less than 100 on 2 occasions. -The diastolic blood pressure ranged from 50-101 from 10/01/16-10/31/16. -The diastolic blood pressure was documented greater than 95 on 4 occasions. -The highest blood pressure was recorded at 178/100 on 10/14/16 at 9:08 a.m. Review of Resident #3's daily blood pressure log for November 2016 revealed: -The blood pressures were recorded daily with a date, time, and MA signature. -The blood pressure parameters to notify the physician were not transcribed on the log. -The systolic blood pressure was documented with a range of 76-173 from 11/01/16-11/30/16. -The systolic blood pressure was documented as greater than 170 on 1 occasion, on 11/15/16 at 8:40 a.m. with a reading of 173/98.	D 273	exact day. Administrator or Manager will sign and date blood pressure log from column "MD notified" Med aides will double check all blood pressure documentation at end of med pass to be sure all out of range blood pressures were reported. Administrator or manager will review all residents blood pressure log forms weekly to assure out of range blood pressures are reported and physicians are notified.	

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D 273	Continued From page 2 -The systolic blood pressure was documented as less than 100 on 5 occasions. -The lowest systolic blood pressure was documented as 76/50 on 11/12/16 at 8:30 a.m. -The diastolic blood pressure was documented with a range of 47-98 from 11/01/16-11/30/16. -The diastolic blood pressure was documented as greater than 95 on 3 occasions. -The diastolic blood pressure was documented as less than 50 on 2 occasions. Review of Resident #3's daily blood pressure log for December 2016 revealed: -The blood pressures were recorded daily with a date, time, and MA signature. -The blood pressure parameters to notify the physician were not transcribed on the log. -The systolic blood pressure was documented with a range of 84-147 from 12/01/-12/07/16 -The systolic blood pressure was documented as less than 100 on 3 occasions. -The lowest systolic blood pressure was documented as 84/68 on 12/03/16 at 8:35 a.m. -The diastolic blood pressure was documented with a range of 58-101 from 12/01/16-12/07/16. -The diastolic blood pressure was documented greater than 95 on 1 occasion, on 12/06/16 at 8:30 a.m. with a reading of 132/101. Interview with the MA on 12/07/16 at 4:25 p.m. revealed: -The MAs were responsible for taking Resident #3's blood pressures and recording those blood pressures on the resident's blood pressure log. -She was aware that Resident #3 had blood pressure parameters and when blood pressures were out of those parameters, the physician should be notified. -When Resident #3's blood pressure was out of range she would report the results to the	D 273		

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D 273	Continued From page 3 Manager. -The MA did not contact the physician but the Manager would. -The MA recorded the blood pressure reading of 132/101 for Resident #3 on 12/06/16 however she did not report this result to the Manager and did not notify the physician. -She knew that the Manager periodically reviewed Resident #3's blood pressure logs and if any were out of range then the Manager would follow up with the physician. -She had not observed Resident #3 with any signs of low blood pressure such as sweating, weakness or feelings of faint. -She had not observed Resident #3 with any signs of high blood pressure such as headache or blurred vision. Interview with the Manager on 12/07/16 at 5:09 p.m. -The Manager was aware that Resident #3 had blood pressure parameters and when blood pressures were out of those parameters, the physician should be notified. -She would usually faxed Resident #3's Blood Pressure logs at the end of the month to the physician but inadvertently did not send the November 2016 blood pressure log. -She had notified the physician of some low blood pressure readings in November but did not report all of the blood pressures recorded out of range on that exact day to the physician. -She knew they needed a better system to track and report when the resident's blood pressure were out of range. -The MAs could contact the physician themselves, however she called most of the time. Based on observation, inteview and record review Resident #3 was not interviewable.	D 273		

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D 273	Continued From page 4 Interview with Resident #3's family member on 12/06/16 at 4:26 p.m. revealed: -The resident had lived at this facility for 13 years. -The resident had a recent illness and had not reached her prior baseline level before that illness, some days were better than other days. Interview with Resident #3's physician on 12/07/16 at 5:46 p.m. revealed: -She thought there had been blood pressure results reported at times but could not give specific dates. -She expected to be notified (the day of) when Resident #3's blood pressures were obtained outside of the ordered parameters.	D 273		
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, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents (#2, #3) observed during the medication passes, including errors with a fast acting insulin (#3), and a medication used to treat high cholesterol (#2).	D 358	Medications/insulin orders that state give with a meal or with meals will be given NO SOONER than 15 minutes before eating. Manager verifies all mealtimes with pharmacy. Any new orders ~~received~~ received to give with a meal or at meals will be printed on MARS with the correct mealtimes.	12/7/16

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D 358	Continued From page 5 The findings are: The medication error rate was 7% as evidence by the observation of 2 errors out of 27 opportunities during the 4:00 p.m. / 5:00 p.m. medication pass on 12/06/16. 1. Review of Resident #3's current FL-2 dated 09/26/16 revealed: -The resident's diagnoses included diabetes mellitus and diabetic neuropathy. -There was an order for Novolog Flexpen, inject 16 units with breakfast, 18 units with lunch and dinner, hold if the blood sugar was less than 80. (NovoLog Flexpen is a pre-filled insulin device used to administer a fast-acting injectable insulin by dialing the number of units to be injected subcutaneously). According to the manufacturer, this insulin starts to lower the blood sugar in about 15 minutes after injection and a meal should be eaten within 5 to 10 minutes after injection, also, an air shot should be done before administering the insulin from the pen to remove air/bubbles and ensure proper insulin dosing. -There was an order to check blood sugars before each meal, if the blood sugar was less than 60, give 8 ounces of orange juice and recheck in 15 minutes, if still less than 60 repeat, and notify the physician. Review of subsequent physician's orders for Resident #3 revealed an order (written on a prescription pad) dated 11/02/16 for NovoLog Flexpen 18 units three times per day. A. Review of the December 2016 medication administration record (MAR) revealed: -There was an entry for NovoLog Flexpen, inject 18 units subcutaneously with breakfast, lunch and dinner. Hold if blood sugar was less than 80.	D 358	Manager will check times during review of MARS at end of month for the next months use. Med aides have been instructed to give by mouth medications no sooner than fifteen minutes before eating. Med aides will give by mouth medications at appropriate time, then take resident directly to dining room and notify dietary staff. Any resident that has an insulin order with meals will not be given insulin sooner than fifteen minutes before eating. If the resident eats in the dining room medaide will give insulin at appropriate time and	

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D 358	Continued From page 6 -The NovoLog was scheduled to be administered at 6:45 a.m., 11:45 a.m., and 4:45 p.m. -There were entries for blood sugar checks to be done before breakfast, lunch, and supper. -The blood sugar checks were scheduled to be performed at 6:30 a.m., 11:30 a.m. and 4:30 p.m. Observation of the 4:00 p.m. medication pass on 12/06/16 revealed: -Resident #3 was alone in her room, lying in a hospital bed, awake, smiling and engaged in conversation with the Medication Aide (MA). -Resident #3's blood sugar was 111 at 4:17 p.m. -The MA administered 18 units of Novolog insulin into Resident #3's right upper arm at 4:19 p.m.. -The MA told Resident #3 supper would be in "a little while". Based on observation, interviews and record review Resident #3 was not interviewable. Interview with Resident #3's family member on 12/06/16 at 4:26 p.m. revealed: -The family member had arrived at the facility before 4:00 p.m. -The family member brought Resident #3 a small container of sugar free ice cream from home, fed the resident the ice cream around 4:00 p.m. and "she ate all of it". -The resident was not as mobile as she once was due to a recent illness and because of that ate meals in her room. -The family member was planning to go to the kitchen to get the residents meal tray and would assist the resident to eat. -There were some days the resident could feed herself and other days she had to be fed. Observation on the North Hall of the facility on 12/06/16 revealed:	D 358	then assist resident to dining room. Med aide will notify dietary staff that resident is ready for tray. If the resident eats in their room, med aide will not give insulin until tray is sitting before resident. Administrator and or manager will monitor times medication is given by observation and reviewing MARs by checking times documented.	

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D 358	Continued From page 7 -There was an announcement made at 4:45 p.m. over the intercom that dinner was being served. -Resident #3's family member walked outside of the resident's room, down the hallway toward the kitchen/dining room at 4:45 p.m. -At 4:47 p.m., Resident #3's family member entered the resident's room with a meal tray. Observation in Resident #3's room on 12/06/16 revealed: -The family member assisted the resident with the meal set-up on the bedside table at 4:48 p.m. -The resident's meal was a bowl of cereal and milk, approximately ½ cup of fresh fruit and 8 ounces of water. -The resident took the first bite of food at 4:51 p.m. -The resident was fed by the family member. -NovoLog insulin was administered 32 minutes before the meal instead of with the meal as ordered. Interview with the MA on 12/06/16 at 5:28 p.m. revealed she thought the insulin could be administered 15 to 30 minutes before a meal. Telephone interview with a nurse with Resident #3's physician's office on 12/07/16 at 11:35 a.m. revealed Novolog insulin should always be given no more than 15 minutes before the meal. Telephone interview with the facility's contracted pharmacy provider on 12/07/16 at 4:48 p.m. revealed: -NovoLog was a fast acting insulin and needed to be given within 15 minutes of a meal. -"You cannot play around with insulin, and the onset is quick". Refer to the interview with Manager on 12/06/16	D 358		

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D 358	Continued From page 8 at 5:50 p.m. Refer to the interview with a second MA on 12/07/16 at 5:24 p.m. B. Observation of the 4:00 p.m. medication pass on 12/06/16 revealed: -Resident #3 was alone in her room, lying in a hospital bed, awake, smiling and engaged in conversation with the Medication Aide (MA). -The MA administered 18 units of Novolog insulin into Resident #3's right upper arm. -The MA did not perform a 2 unit air shot prior to dialing up and administering the 18 units of insulin with the Novolog Flexpen. Based on observation, interviews and record review Resident #3 was not interviewable. Interview with the MA on 12/06/16 at 5:28 p.m. revealed she did not realize the insulin pen had to be primed with a 2 unit air shot before use. Interview with the Manager on 12/06/16 at 5:50 p.m. revealed: -Resident #3 was the only resident at the facility that was on insulin. -The MAs recently had a class from a contracted provider on diabetic care but was unsure if the use of the Flexpen was reviewed. -The facility was using insulin bottles and recently switched to the Flexpen. -The Manager would refer to the NovoLog Flexpen's manufacturer's instructions regarding the air shot technique and would train the MA staff. Interview with the Manager on 12/07/16 at 10:48 a.m. revealed: -She did not know to tell the MA's to do an air	D 358	Med aides have been instructed to perform a 2 unit air shot to prime the needle of Novolog Flexpen before each use. Manager spoke with pharmacy on 12/7/16 and requested a Novolog Flexpen manufacturer instruction * sheet. Manager also printed an instruction sheet from a ** Novolog Flexpen site. Manager met with 2 of 3 med aides on 12/7/16 to go over instruction sheet. Both med aides understood and performed a 2 unit air shot using a Novolog Flexpen. A copy of the	12/7/16

* see page - 2B
** see page - 3C

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D 358	Continued From page 9 shot when the Flexpen was used to administer NovoLog for Resident #3. -There was not a manufacturer instruction insert for the NovoLog Flexpen, but she would call the contracted pharmacy to obtain one. Telephone interview with the facility's contracted pharmacy provider on 12/07/16 at 4:48 p.m. revealed: -The facility received Resident #3's Novolog Flexpens from the pharmacy in plastic bags instead of the original packaging. -The manufacturer's instruction insert was not sent to the facility because the insert would get wet inside the plastic bags when refrigerated. Interview with a second MA on 12/07/16 at 5:24 p.m. revealed: -She had worked at the facility since 1992. -She had never done an air shot when she administered Resident #3's NovoLog, she was "never told to do this". Interview with the Manager on 12/07/16 at 6:00 p.m. revealed: -She had obtained a copy of the manufacturer's instructions for the air shots from the pharmacy provider. -She had completed a training session with two of the MAs on how to perform the air shots. 2. Review of Resident #2's current FL-2 dated 03/28/16 revealed: -The resident's diagnoses included quadriplegia, insomnia, osteoporosis, cervical muscle spasm and a history of breast cancer. -There was an order for Lovastatin 20 mg every day. (Lovastatin is a medication used to treat high cholesterol).	D 358	instruction sheet was placed in MAR book and copies were given to med aides. Manager spoke with second shift med aide by phone 12/7/16 to go over how to do an air shot. Med aide stated she understood how to do and would do an air shot each time she used the Novolog Flexpen. Manager requested that pharmacy send all instruction sheets with new insulin orders.	

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D 358	Continued From page 10 Review of a subsequent hospital discharge summary, signed by a physician on 05/27/16 revealed an order to take Lovastatin 20mg with supper. Review of the December 2016 medication administration record (MAR) for Resident #2 revealed: -There was an entry for Lovastatin 20 mg take one tablet daily with a meal. -Lovastatin was scheduled to be administered at 4:00 p.m. Observation of the 4:00 p.m. medication pass on 12/06/16 revealed the medication aide (MA) administered one tablet of Lovastatin 20 mg at 3:33 p.m. Observation in the dining room on 12/06/16 at 5:00 p.m. revealed food was served to the residents eating in the dining room. Interview with the MA on 12/06/16 at 5:28 p.m. revealed she thought the medication could be given 15-30 minutes before the meal. Interview with Resident #2 on 12/07/16 at 4:00 p.m. revealed: -The resident always took her medications around 4:00 p.m. each day. -The resident was not aware that Lovastatin was ordered to take with a meal. -She had never eaten a meal with her 4:00 p.m. medications. -The resident did not eat any food on 12/06/16 after 3:00 p.m. until her supper meal around 5:00 p.m. -The resident ate in the dining room around 5:00 p.m. on 12/06/16.	D 358		

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D 358	Continued From page 11 Documentation from the medication pass observed on 12/06/16 revealed Lovastatin was administered one hour and 27 minutes prior to a meal. Interview with the Manager on 12/06/16 at 5:50 p.m. revealed: -They were not aware that Resident #2's Lovastatin was scheduled for 4:00 p.m. on the MAR. -The Manager would contact Resident #2's physician. Telephone interview with a nurse with Resident #3's physician's office on 12/07/16 at 11:35 a.m. revealed the nurse had spoken with the physician concerning meds ordered with meals and it was the physician's expectation that the medication should be given within 15 minutes before the meal. Refer to the interview with Manager on 12/06/16 at 5:50 p.m. Refer to the interview with a second MA on 12/07/16 at 5:24 p.m. _____ Interview with the Manager on 12/06/16 at 5:50 p.m. revealed the Manager thought when a medication was ordered with a meal, the medication should be administered 15 minutes before the meal. Interview with a second MA on 12/07/16 at 5:24 p.m. revealed she thought when a medication was ordered with a meal, the medication should be administered 15 minutes before the meal.	D 358		

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