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
	HAL092131	A. BUILDING: _____ B. WING _____	R 12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 Wake County Human Services conducted a follow-up survey on 12/14/16 - 12/15/16.	{D 000} D358	Addendum per telephone with Donna Horton on 1/26/17: Record audits included orders and MARs and meds on hand. Flexlin inservice was coordinated through the primary pharmacy provider. Random med pass observations are included in the audits for monitoring. The completion date is 1/16/17. W. Williams 1/26/17	
{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. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the prescribing practitioner for 1 of 9 residents (#8) observed during medication passes which included errors with the administration of insulin. The findings are: The medication error rate was 6% as evidenced by the observation of 2 errors out of 30 opportunities during the 4:00 p.m./5:00 p.m. medication pass on 12/14/16 and the 7:00 a.m./8:00 a.m. medication pass on 12/15/16. Review of Resident #8's current FL-2 dated	{D 358}	See Attached 1/26/17 RECEIVED JAN 17 2017 ADULT CARE LICENSURE SECTION RALEIGH	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Donna E Horton	Administrator	1-17-17

* The plan of correction with addendum was reviewed and accepted on 1/26/17. Refer to the addendum on this page of the Statement of Deficiencies.
W. Williams 1/26/17

Phoenix Assisted Care
HAL-092-131
Plan of Correction
DHSR Survey 12/15/16

10A NCAC 13F.1004(a) Medication Administration;

(a) An adult care home shall assure that the preparation and administration of medications, prescriptions and non-prescriptions, and treatments by staff are in accordance with:

1. Orders by a licensed prescribing practitioner which are maintained in the residents record: and
2. Rules in this section and the facilities policies and procedures.

Plan of Correction:

The Administrator/QC staff audited records to assure residents were receiving medications as ordered. 12/16/16

Staff retrained on proper medication administration per physician orders and manufacturing instructions. 12/16/16

Flex Pen Inservice scheduled for December 16, 20176 at 2:30 pm for all Supervisors-in-Charge, and all Medication Aides.
12/16/16

Resident # 8 is receiving medications as ordered. 12/16/16

Phoenix Assisted Care

HAL-092-131

Plan of Correction

DHSR Survey 12/15/16

Monitoring System:

Administrator/Quality Assurance Staff and/or Regional Director will randomly audit medication administrations weekly x 4 weeks then monthly thereafter to assurethe medications are given according to physicians orders and manufacturer's guidelines 12/16/16

Any staff member not following procedures will receive disciplinary action to include retraining, reprimands and/or termination. 12/16/16

* Refer to addendum on page 1 of the Statement of Deficiencies. W. Williams 11/26/19 POC date: 1/16/17

Dona E Norton 1-17-17

Signature/Administrator Date

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{D 358}	Continued From page 1 08/22/16 revealed: - The resident's diagnoses including diabetes mellitus, coronary artery disease, hyperlipidemia, and hypertension. - There was a physician's order dated 08/22/16 for fingerstick blood sugars (FSBS) 3 times a day with Novolog sliding scale insulin (SSI): notify physician if <70, 71-150 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351 - 400 = 10 units, > 400 = 12 units. Notify physician if FSBS > 500. (Novolog is a rapid-acting insulin used to lower blood sugar). Review of Resident #8's physician's orders revealed there was an order dated 11/14/16 for Novolog insulin 6 units with lunch and dinner. Review of the December 2016 Blood Sugar Monitoring log and the medication administration record (MAR) for Resident #8 revealed: - The resident's blood sugar ranged from 63 - 303. - The Novolog sliding scale insulin was scheduled to be administered at 6:30 a.m., 11:30 a.m., and 5:00 p.m. - The Novolog insulin with lunch and dinner was scheduled to be administered at 12:00 p.m. and 4:00 p.m. Observation on 12/14/16 during the 4:00 p.m./5:00 p.m. medication pass revealed: - The medication aide (MA) checked Resident #8's blood sugar at 4:19 p.m. and it was 176. - The MA said he would administer 2 units of Novolog insulin for the sliding scale and the 6 units of the scheduled Novolog insulin to Resident #8 (total of 8 units). - The MA took the cap off the Novolog pen, dialed to 2 units and pressed the button prior to	{D 358}	See ATTACHED	

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{D 358}	Continued From page 2 screwing the needle on the pen. (According to the manufacturer's instructions, after the needle is in place, an air shot should be done to avoid injecting air and ensure proper dosing). - The MA dialed the Novolog pen to 8 units and injected the insulin into Resident #8's left upper arm at 4:25 p.m., holding the pen in the resident's arm 1-2 seconds prior to removing it. (According to manufacturer instructions, the needle should be kept in the skin for at least 6-10 seconds to ensure proper dosing.) - The resident was served and started eating her evening meal at 5:00 p.m. in the dining room, 35 minutes after receiving Novolog, a rapid-acting insulin. (According to the manufacturer, a meal should be eaten within 5-10 minutes of taking Novolog). - The MA did not administer the Novolog sliding scale insulin or the scheduled dose of Novolog insulin to Resident #8 as ordered. Interview on 12/14/16 at 7:10 p.m. with the MA revealed: - He dialed 2 units (insulin) and did an air shot to make sure there were no bubbles. - The needle was put on after the air shot. - He did not know the needle was supposed to be attached to the pen before doing an air shot. - Dinner was served at 5:00 p.m., 5:15 p.m., or 5:30 p.m. and the insulin was to be administered 30 minutes prior to the meal. - He thought insulin could be administered up to 30 minutes before a meal even if it was ordered to be given with the meal. - He was aware the insulin pen should be held in the skin after doing the injection, but he could not remember how long it should be held in. - The facility pharmacy did training on insulin pens several years ago but he could not remember when.	{D 358}	See ATTACHED	

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(D 358)	Continued From page 3 Interview on 12/14/16 at 7:25 p.m. with the Administrator revealed: - Resident #8 was supposed to be administered insulin when she was ready to be served her meals. -A training was scheduled with the pharmacy within the last 2 months, but it was cancelled. - She would call the pharmacy to set up training for MAs on insulin pens and administration. - A system would be put in place for coordinating insulin administration with meal times. Interview on 12/15/16 at 3:53 p.m. with Resident #8 revealed: - She received insulin in the morning and it was administered while she was still in bed. - She would get out of bed, get dressed, and wait for someone to take her to the dining room for breakfast. - It took about 30 minutes to get ready and be in the dining room to eat breakfast. - At lunch time, she went to the medication room located in the dining room for her insulin and then went to sit at the dining room table to eat. - It took about 10 - 15 minutes after the insulin was administered to receive her meal and start eating. - In the evening, she would have the insulin administered in her room. - She would then wait for staff to take her to the dining room for dinner. - it would be a half-hour wait to get to the dining room to eat. - Resident #8 had not felt bad after taking the insulin and waiting to eat, but sometimes (could not remember when) staff gave her orange juice to drink for low blood sugar. Interview on 12/15/16 at 6:47 p.m. with Resident	{D 358}	See ATTACHED	

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(D 358)	Continued From page 4 #8's physician revealed: - Insulin pens needed to have air shots done correctly and medication aides needed to be trained on the proper procedure to be done. - Insulin administration "with meals" means 5-10 minutes before the resident begins eating because the insulin was fast acting. - Resident #8 received her insulin too early. - The expectation for administering insulin by pen was to hold the needle in the skin for 6 seconds, after injection, according to the manufacturer's instructions so that all of the dosage would be delivered.	(D 358)	See ATTACHED	