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
	HAL005015	A. BUILDING: _____ B. WING _____	01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST RIDGE	151 VILLAGE PARK DRIVE WEST JEFFERSON, NC 28694

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D 000	Initial Comments The Adult Care Licensure Section and the Ashe County Department of Social Services conducted an annual survey on January 18-19, 2017.	D 000		
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: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure medications, Novolog and Levemir, were administered as ordered by a licensed prescribing practitioner for 1 of 6 residents (#5) observed during a medication pass. The findings are: Review of Resident #5's current FL2 dated 9/9/16 revealed: -Diagnoses included dementia and diabetes. -Medication orders for Levemir, 20 units subcutaneously (SQ) each morning at 6am, and 5 units SQ in the evening at 9pm. (Levemir is a long acting insulin used to lower blood sugars in diabetics.) -Medication orders for Novolog, to be given per sliding scale before meals. (Novolog is a quick	D 358	Deficient team member was removed from med cart and medication administration responsibilities the day of infraction. A plan of protection was put into place on the day of infraction requiring all Med Tech's to review Medication Administration policy and education materials and sign a staff in-service sheet upon completion showing understanding. A mandatory Med Tech meeting was conducted on January 24, 2017 to review diabetic protocol and med tech responsibilities. All Med Tech's are being required to complete a 6 hour med tech class. The class is being offered on January 31st, February 15th, and February 20th. Medication administration observations are being conducted on all med techs. Executive Director, Resident Services Consultant (RN), Assisted Living Wellness Director and Horizons (SCU) Wellness Director will monitor situation to prevent future occurrences. Quarterly medication administration observations to be completed for each med tech going forward to ensure compliance.	3/5/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Executive Director (X6) DATE 2/14/17

Plan of Correction was reviewed and Acknowledged on 2/14/17 by Joseph Cline, RN.

Joseph Cline, RN

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acting insulin used to lower blood sugars in diabetics around meal times.)

Review of Resident #5's sliding scale order dated 9/9/16 for administration of Novolog insulin revealed:
-Blood sugar of 151-200, give 3 units of insulin.
-Blood sugar of 201-250, give 5 units of insulin.
-Blood sugar of 251-300, give 7 units of insulin.
-Blood sugar of 301-350, give 9 units of insulin.
-Blood sugar of 351-400, give 11 units of insulin.
-Blood sugar of greater than 400, call Medical Doctor (MD).

Observation of a noon medication pass on 1/18/17 at 11:45am revealed:
-Resident #5's finger stick blood sugar (FSBS) was 241, which necessitated a sliding scale dose of Novolog insulin of 5 units.
-Staff A, Medication Aide (MA), pulled Resident #5's labeled plastic bag containing a bottle of Levemir insulin from the medication cart.
-Staff A drew 5 units of Levemir insulin into an insulin syringe and began walking toward Resident #5 to administer the insulin.
-At this point, survey staff stopped Staff A and asked her to check the label and insulin bottle from which she had drawn the insulin.
-Staff A then realized she had drawn a dose of Levemir insulin instead of Novolog insulin to give to Resident #5 for his noontime dose of sliding scale.
-Staff A then discarded the dose of Levemir insulin, and obtained Resident #5's Novolog insulin from the medication cart.
-The Novolog insulin for Resident #5 was labeled and in an original manufacturer's box.
-Staff A drew 5 units of Novolog insulin into an insulin syringe and administered it SQ into Resident #5's abdomen.

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Interview with Staff A on 1/18/17 at 11:50am revealed she was confused about Resident #5's two types of insulin because "they were in different packaging."

Observation of Resident #5's medications on hand on 1/19/17 at 11:15am revealed:
-Resident #5's Levemir insulin was in a small plastic bag labeled, Take 20 units SQ at 6am each morning and 5 units each evening, with a dispense date of 12/19/16.
-The Levemir was dispensed from the facility's pharmacy provider.
-Resident #5's Novolog was in an original manufacturer's box labeled, Use as directed, with a dispense date of 1/12/17.
-The Novolog insulin had been dispensed from the facility's local back-up pharmacy.

Interview with the regional quality improvement/assurance coordinator on 1/19/17 at 12:10pm revealed:
-The facility did not have a specific policy on insulin administration.
-All MAs had to take the state approved 15 hour training regardless of how long they had been MA.
-All MAs also have special diabetic training.
-MAs are supposed to check the Medication Administration Records (MARs) against the prescription labels before administering medications.

Interview with Resident #5 on 1/9/17 at 11:30am revealed:
-He believed he received his insulin as ordered by his physician.
-He had never had a problem with his insulin or a reaction to his insulin.

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Review of Resident #5's December 2016 and January 2017 MARs revealed:
-In December 2016, Resident #5's FSBS ranged from 83 to 374 and the Novolog sliding scale was documented as administered correctly.
-In January 2017, Resident #5's FSBS ranged from 90 to 350 and the Novolog sliding scale was documented as administered correctly.

Review of Resident #5's record revealed his hemoglobin A1c level had improved from 8.8% on 2/11/16 to 6.7% on 9/30/16. (Hemoglobin A1c levels show an average blood sugar level over a 3 month period with nondiabetic levels of 5.7% or less, and a therapeutic goal of 7.0% or less for diabetic residents.)

Review of the facility's policy on Medication Administration revealed:
-The team member (MA) will verify that directions on the label of medication match the order on the MAR.
-If there are any differences in directions, the team member will verify directions with the current order on file in the resident's chart.

The facility failed to assure Resident #5 received his insulin as ordered by his licensed prescribing practitioner. Administration of the long acting Levemir insulin instead of the quick acting Novolog insulin for sliding scale coverage of the lunch meal would result in elevated blood sugars above the already elevated FSBS of 241. The facility's failure to administer Resident #5's insulins as ordered was detrimental to his health and constitutes a Type B Violation.

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D 358	Continued From page 4 On 1/18/17, the facility provided the following Plan of Protection: -The facility will immediately remove the MA in violation of the rule from medication administration duties. -All facility MAs will receive and review written medication administration expectations in accordance with state regulations and facility's policies and procedures. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 5, 2017.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to assure a resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations in the area of medication administration. The findings are: Based on observations, record reviews, and interviews, the facility failed to assure medications, Novolog and Levemir, were administered as ordered by a licensed prescribing	D912	Deficient team member was removed from medication administration duties on the day of infraction. Reeducation on Resident's Rights through in-service scheduled for 2/23/17. Reeducation on the rights of a resident regarding medication administration through a required 6 hour Med Tech training to be completed on one of the following dates: January 31st, February 15th, or February 20th. Medication administration observations are being conducted on all med tech's.	3/5/17

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D912	Continued From page 5 practitioner for 1 of 6 residents (#5) observed during a medication pass. [Refer to D 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation.)]	D912	Executive Director, Resident Services Consultant (RN), Assisted Living Wellness Director and Horizons (SCU) Wellness Director will monitor situation to prevent future occurrences. Quarterly medication administration observations will be completed to ensure resident rights compliance.	