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
	HAL076003	A. BUILDING: _____ B. WING _____	03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSS ROAD RETIREMENT COMMUNITY	1302 OLD COX ROAD ASHEBORO, NC 27203

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 8-10, 2017, and March 13, 2017.	D 000	RECEIVED APR 18 2017 ADULT CARE LICENSURE SECTION RALEIGH	
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 observations, interviews and record reviews, the facility failed to notify the physician for 2 of 5 sampled residents (Resident #3 and #14) regarding an order to notify the physician of weekly blood sugar (BS) results (#3), and BS results over 400 (#14). The findings are: A. Review of Resident #3's current FL2 dated 04/15/16 revealed: -Diagnoses included pathological fracture, end stage renal failure, congestive heart failure, anemia and diabetes. -An order for a BS to be checked at 6:30 am, 11:30 am and 4:30 pm. Review of Resident #3's subsequent physician's orders dated 01/19/17 revealed an order for a BS before meals and at bedtime, (8:00 am, 4:00 pm and 10:00 pm) and report to doctor every week. Review of Resident #3's subsequent physician's orders dated 03/02/17 revealed an order for a BS before meals and at bedtime, (8:00 am, 4:00 pm	D 273	Worked with pharmacy to correct and ensure proper documentation. RCD will be responsible for faxing of any blood sugar readings and keep confirmation.	4/12/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director — 04/12/2017

Reviewed and accepted with addendum on page 37 of 54. AJS 4/25/17

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D 273	Continued From page 1 and 10:00 pm) and report to doctor every week. Review of Resident #3's record revealed no documentation of BS reported to the physician weekly. Review of Resident #3's electronic Medication Administration Record (eMAR) for January 2017 revealed: -There was no entry for a BS before meals and at bedtime (8:00 am, 4:00 pm and 10:00 pm) and report to doctor every week. -An entry to check FSBS before each meal was transcribed onto the eMAR and scheduled daily at 7:30 am, 11:30 am, and 4:30 pm from 01/01/17 to 01/19/17. -An entry to check FSBS before each meal was transcribed onto the eMAR and scheduled daily at 8:00 am, 12:00 pm, and 5:00 pm from 01/19/17 to 01/31/17. Review of Resident #3's electronic Treatment Administration Record (eTAR) for January 2017 revealed: -An entry was transcribed to check Blood Glucose (BG) before meals and at bedtime and report to doctor every week with scheduled checked at 8:00 am, 4:00 pm, and 10:00 pm. -BG range was between 62-400. Review of Resident #3's eMAR for February 2017 revealed: -There was no entry for a BS before meals and at bedtime (8:00 am, 4:00 pm and 10:00 pm) and report to doctor every week. -An entry to check FSBS before each meal was transcribed onto the eMAR and scheduled daily at 8:00 am, 12:00 pm, and 4:00 pm. Review of Resident #3's eTAR for February 2017	D 273		

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D 273	Continued From page 2 revealed: -An entry was transcribed to check Blood Glucose (BG) before meals and at bedtime and report to doctor every week with scheduled check at 8:00 am, 4:00 pm, and 10:00 pm. -BG range was between 83-378. Review of Resident #3's eMAR for March 1 at 8:00 am - March 8, at 10:00 pm 2017 revealed: -There was no entry for a BS before meals and at bedtime, (8:00 am, 4:00 pm and 10:00 pm) and report to doctor every week. -An entry to check FSBS before each meal was transcribed onto the eMAR and scheduled daily at 8:00 am, 12:00 pm, and 4:00 pm. Review of Resident #3's eTAR for March 1, 2017 at 8:00 am - March 9, 2017 at 8:00 am revealed: -An entry was transcribed to check Blood Glucose (BG) before meals and at bedtime and report to doctor every week with scheduled check at 8:00 am, 4:00 pm, and 10:00 pm. -BG range was between 96-249. Interview on 03/09/17 at 12:15 pm with Resident #3 revealed: -The medication aide (MA) checked "my blood sugar 3 times a day". -The MA took her blood sugar and gave insulin if she needed it. -She felt like she received the insulin she needed. -"It is hard to control my blood sugar". "I do not know if they tell the doctor about my blood sugars". Telephone interview on 03/10/17 at 9:15 am and 03/10/17 at 10:00 am with Registered Nurse (RN) at Resident #3's primary care physician's office revealed: -There was no documentation of any blood	D 273		

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sugars done weekly and reported to MD per order dated 11/10/16 in the record at the office.
-She was not aware the blood sugars for Resident #3 were not sent to the doctor's office.
-It was her expectation that the orders were followed, documented completely and reported as ordered.

Refer to interview on 03/09/17 at 10:10 am and at 2:20 pm with the Director of Nursing (DON).

Refer to interview on 03/09/17 at 2:05 pm with the Administrator.

B. Review of Resident #14's current FL2 dated 01/26/17 revealed:
-Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus and hypertension.
-There were no orders for insulin listed on the FL2.

Review of Resident #14's Resident Register revealed an admission dated of 08/03/15.

Review of Resident #14's physician's orders dated 01/26/17 revealed an order for Novolin R (Novolin R is a fast acting insulin used to decrease elevated blood sugar) to be given as needed for the fingerstick blood sugars (FSBS) checked daily at 6:00 am and 4:00 pm as follows:
Blood sugar range less than 150 give 0 units.
Blood sugar range between 150-200 give 2 units.
Blood sugar range between 201-250 give 4 units.
Blood sugar range between 251-300 give 6 units.
Blood sugar range between 301-350 give 8 units.
Blood sugar range between 301-350 give 8 units.
Blood sugar range between 351-400 give 10 units.
If over 400 call office or provider on call.

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D 273	Continued From page 4 Review of Resident #14's subsequent physician's orders dated 02/07/17 revealed an order for Novolin R to be given with the same parameters from the order dated 01/26/17. Review of Resident #14's January 2017 electronic Medication Administration Record (eMAR) revealed there were 2 of 2 opportunities when the physician should have been notified as follows: -On 01/27/17 at 4:00 pm, the blood sugar result was 401. -On 01/29/17 at 4:00 pm, the blood sugar result was 547. Review of Resident#14's record revealed no documentation the physician had been notified for the elevated FSBSs on 01/27/17 or 01/29/17. Review of resident #14's February 2017 eMAR revealed there were 3 of 3 opportunities when the physician should have notified as follows: -On 02/07/17 at 4:00 pm, the blood sugar result was 431. -On 02/08/17 at 4:00 pm, the blood sugar result was 418. -On 02/10/17 at 4:00 pm, the blood sugar result was 475. Review of Resident#14's record revealed no documentation the physician had been notified for the elevated FSBSs on 02/07/17, 02/08/17 or 02/10/17. Telephone interview on 03/13/17 at 10:50 am with a representative from Resident #14's physician's office revealed: -There was no documentation the physician had been contacted on 01/27/17, 01/28/17, 02/07/17,	D 273		

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D 273	Continued From page 5 02/18/17 or 02/10/17 for elevated blood sugars. -The physician was in the facility "a lot" and in frequent contact with Resident #14. -Resident #14 was seen by the physician in the facility and in the office as needed. -The physician reviewed the eMARs when he saw Resident #14 in the facility. -The physican "had no concerns" about the insulin administered to Resident #14 and the physician was very pleased with the care given to Resident #14 at the facility. Interview on 03/13/17 at 11:30 am with Resident #14 revealed: -"They check my sugar a lot". -The MA took her blood sugar and gave the resident insulin if she needed it. -"I get a shot if it's high". -She felt like she got the insulin she needed. Refer to interview on 03/09/17 at 10:10 am and at 2:20 pm with the Director of Nursing (DON). Refer to interview on 03/09/17 at 2:05 pm with the Administrator. Interview on 03/09/17 at 10:10 am and at 2:20 pm with the Director of Nursing (DON) revealed: -She completed initial training with staff as well as annual training on diabetes which included administration and documentation of insulin per sliding scale. -She provided a policy for common sites used for insulin injections and different types of insulin. -She had no written policy for insulin administration per sliding scale. -She was not aware the blood sugars for Resident #3 was not sent to the doctor's office. -"There are no reviews of the eMARs before the new month comes out for accuracy or new	D 273		

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D 273	Continued From page 6 orders". -"There are no reviews of the eMARs at the end of the month for accuracy or holes". -There was no documentation the facility had notified the doctor's office about the blood sugars for Resident #3 Interview on 03/09/17 at 2:05 pm with the Administrator revealed it was his expectation the facility follow the doctors' orders and document appropriately to show the work was done.	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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure documentation of administration of medications as ordered by a licensed prescribing practitioner, which included errors with administration and omissions, for 3 of 4 residents ordered sliding scale insulin (SSI) of Novolin R (#3, #14), SSI of Novolog FlexPen (#13). The findings are:	D 358	Staff has been retrained on diabetes and proper use of meters and insulin administration. See attached list of people who attended class. MD's have signed a policy on blood sugar parameters and placed in residents charts. 2 med-techs are verifying correct amount of insulin and signing on Sliding Scale Insulin log. Pharmacy corrected missing documentation box on eMAR for amount of Sliding Scale Insulin administered. See attached letter from Southern Pharmacy. Pharmacy staff RN's checked all orders on eMAR against chart orders.	04/12/17

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D 358	Continued From page 7 A. Review of Resident #3's current FL2 dated 04/15/16 revealed: -Diagnoses included of pathological fracture, end stage renal failure, congestive heart failure, anemia and diabetes. -An order for Novolin R (Novolin R is a fast acting insulin used to decrease elevated blood sugars) to be given at 6:30 am, 11:30 am, and 4:30 pm, every day and according to the sliding scale (SSI) parameters as follows: Blood Sugar (BS) range between 0-150 give 0 units. BS range between 151-200 give 2 units. BS range between 201-250 give 4 units. BS range between 251-300 give 6 units. BS range between 301-350 give 8 units. BS range between 351-400 give 10 units. BS range between 401-450 give 12 units. If BS < 60 or > 450 call MD. Review of Resident #3's subsequent physician's orders dated 01/05/17 revealed: -An order to check Finger Stick Blood Sugar (FSBS) before each meal at 6:30 am, 11:30 am, and 4:30 pm, every day and Novolin R to be administered per SSI as follows: BS range between 0-80 give 0 units. BS range between 81-140 give 2 units. BS range between 141-180 give 4 units. BS range between 181-220 give 6 units. BS range between 221-280 give 8 units. BS range between 281-320 give 10 units. BS > 321 give 12 units. -An order for a BS to be checked and Novolin R to be given before dialysis, Monday, Wednesday and Friday at 10:00 am according to the sliding scale as follows: BS range between 0-150 give 0 units. BS range between 151-200 give 2 units.	D 358		

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D 358	Continued From page 8 BS range between 201-250 give 4 units. BS above 250 give 6 units. Review of Resident #3's subsequent physician's orders dated 01/19/17 revealed: -An order to check FSBS before each meal at 6:30 am, 11:30 am, and 4:30 pm, every day and Novolin R to be administered per SSI as follows: BS range between 0-150 give 0 units. BS range between 151-200 give 1 units. BS range between 201-250 give 2 units. BS range between 251-300 give 3 units. BS range between 301-350 give 4 units. BS range between 351-400 give 5 units. BS range between 401-450 give 6 units. If BS > 450 call MD. -An order for a BS to be checked and Novolin R to be given before dialysis, Monday on Wednesday and Friday at 10:00 am according to the sliding scale as follows: BS range between 0-150 give 0 units. BS range between 151-200 give 2 units. BS range between 201-250 give 4 units. BS above 250 give 6 units. -An order for a BS before meals and at bedtime, (8:00 am, 4:00 pm and 10:00 pm) and report to doctor every week. Review of Resident #3's subsequent physician's orders dated 03/02/17 revealed: -An order for a FSBS to be checked and Novolin R to be given at 6:30 am, 11:30 am, and 4:30 pm, every day according to the sliding scale as follows: BS range between 0-150 give 0 units. BS range between 151-200 give 1 units. BS range between 201-250 give 2 units. BS range between 251-300 give 3 units. BS range between 301-350 give 4 units. BS range between 351-400 give 5 units.	D 358		

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D 358	Continued From page 9 BS range between 401-450 give 6 units. If BS > 450 call MD. -An order for a BS to be checked and Novolin R to be given before dialysis on Monday, Wednesday and Friday at 10:00 am according to the sliding scale as follows: BS range between 0-150 give 0 units. BS range between 151-200 give 2 units. BS range between 201-250 give 4 units. BS above 250 give 6 units. -An order for a BS before meals and at bedtime, (8:00 am, 4:00 pm and 10:00 pm) and report to doctor every week. Review of Resident #3's electronic Medication Administration Record (eMAR) for January 2017 revealed: -An entry to check FSBS before each meal was transcribed onto the eMAR and scheduled daily at 7:30 am, 11:30 am, and 4:30 pm from 01/01/17 to 01/19/17. -An entry to check FSBS before each meal was transcribed onto the eMAR and scheduled daily at 8:00 am, 12:00 pm, and 5:00 pm from 01/19/17 to 01/31/17. -On 01/14/17 at 7:30 am, BS result was 132 and 6 units of SSI was administered, and 2 units should have been administered. -On 01/17/16 at 11:30 am, BS result was 297 and 8 units of SSI was administered and 10 units should have been administered. -Insulin per SSI was not documented as administered for 81 out of 93 opportunities. Examples were as follows: -On 01/06/17 at 7:30 am, BS result was 158, no insulin was documented as administered, and 4 units should have been administered. -On 01/11/17 at 7:30 am, BS result was 170, no insulin was documented as administered and 4 units should have been administered.	D 358		

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D 358	Continued From page 10 -On 01/12/17 at 11:30 am, BS result was 367, no insulin was documented as administered and 12 units should have been administered. -An entry to check BS before dialysis and administer SSI was transcribed onto the eMAR from 01/01/17 to 01/31/17 and scheduled to be administered at 10:00 am. -Insulin per SSI was documented as administered incorrectly with examples as follows: -On 01/04/17 at 10:00 am, BS result was 305 and 12 units was documented as administered, and 6 units should have been administered. -On 01/11/16 at 10:00 am, BS result was 262 and 10 units was documented as administered, and 6 units should have been administered. -On 01/13/16 at 10:00 am, BS result was 301 and 12 units was documented as administered, 6 units should have been administered. -There was no entry for a BS before meals and at bedtime, (8:00 am, 4:00 pm and 10:00 pm) and report to doctor every week. Review of Resident #3's eMAR for February 2017 revealed: -An entry to check FSBS before each meal was transcribed onto the eMAR and scheduled to be administered daily at 8:00 am, 12:00 pm, and 4:00 pm. -Insulin per SSI was not documented as administered for 84 out of 84 opportunities with examples as follows: -On 02/06/17 at 8:00 am, BS result was 343, no insulin was documented as administered, and 4 units should have been administered. -On 02/13/17 at 4:00 pm, BS result was 178, no insulin was documented as administered, and 1 unit should have been administered. -On 02/24/17 at 4:00 pm, BS result was 320, no insulin was documented as administered, and 4 units should have been administered.	D 358		

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D 358	Continued From page 11 -An entry to check BS before dialysis and administer SSI was transcribed onto the eMAR from 02/01/17 to 02/28/17 and scheduled to be administered at 10:00 am. -There was no entry for a BS before meals and at bedtime, (8:00 am, 4:00 pm and 10:00 pm) and report to doctor every week. Review of Resident #3's eMAR for March 1 at 8:00 am - March 8, 2017 at 12:00 pm revealed: -An entry to check FSBS before each meal was transcribed onto the eMAR and scheduled to be administered daily at 8:00 am, 12:00 pm, and 4:00 pm. -Insulin per SSI was not documented as administered for 22 out of 22 opportunities with examples as follows: -On 03/01/17 at 4:00 pm, BS result was 185, no insulin was documented as administered, and 1 unit should have been administered. -On 03/02/17 at 4:00 pm, BS result was 188, no insulin was documented as administered, and 1 unit should have been administered. -On 03/05/17 at 4:00 pm, BS result was 202, no insulin was documented as administered, and 2 units should have been administered. -An entry to check BS before dialysis and administer SSI was transcribed onto the eMAR and documented from 03/01/17 to 03/08/17 and administered as ordered at 10:00 am. -An entry to check BS before dialysis and use SSI was transcribed onto the eMAR and documented as administered daily at 10:00 am. -There was no entry for a BS before meals and at bedtime, (8:00 am, 4:00 pm and 10:00 pm) and report to doctor every week. Interview on 03/09/17 at 9:40 am with a medication aide (MA) revealed she administered insulin according to the sliding scale as ordered	D 358		

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D 358	Continued From page 12 for Resident #3's blood sugar results, but was not sure how to document the insulin administration. There was no space to enter the amount of insulin administered on the eMARs and did not report it. Interview on 03/09/17 at 9:45 am with a second MA revealed she administered insulin according to the sliding scale as ordered for Resident #3's blood sugar results, but was not sure how to document the insulin administration because there was no space to enter it on the MARs in some cases and did not report it. Interview on 03/09/17 at 12:15 pm with Resident #3 revealed: -The MA checked her blood sugar 3 times a day. -The MA took her blood sugar and administered her insulin if she needed it. -She felt like she received the insulin she needed. -"It is hard to control my blood sugar". Telephone interview on 03/10/17 at 9:15 am and on 03/10/17 at 10:00 am with the Registered Nurse (RN) at Resident #3's primary care physician's office revealed: -The office had no record of facility notification of sliding scale insulin administer incorrectly or not at all. -There was no documentation of any blood sugars done weekly and reported to physician per the order dated 11/10/16. -It was her expectation that the orders were followed, documented completely and reported as ordered. -Too much SSI can result in a hypoglycemic episode and too much can result in a HgB A1C (Hemoglobin A1C is a blood test doctors use to determine average blood sugar levels over the past three months) out of control.	D 358		

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D 358	Continued From page 13 -Resident #3 was seen in the office on 03/09/17 and her HgB A1C was 7.6 which was high. -Resident #3's HgB A1C before that was 6.2 and that was high also. Refer to interview on 03/09/17 at 9:40 am with a Medication Aide (MA). Refer to interview on 03/09/17 at 9:45 am with a second MA. Refer to interview on 03/09/17 at 10:00 am with a contracted Pharmacy Consultant. Refer to interviews on 03/09/17 at 10:10 am and at 2:20 pm with the Director of Nursing (DON). Refer to interview on 03/09/17 at 2:05 pm with the Administrator. B. Review of Resident #13's current FL2 dated 11/08/16 revealed: -diagnoses included of coronary artery disease and diabetes. -An order for Lantus (a long acting insulin) insulin 30 units each night. -An order for Novolog insulin (a rapid acting insulin) 10 units each morning. Review of Resident #13's record revealed a physician's order dated 02/25/17 for Novolog FlexPen (a rapid acting insulin used to decrease elevated blood sugars) insulin injection three times a day, before meals based on blood sugar readings [fingerstick blood sugar (FSBS)] using the following sliding scale insulin (SSI) parameters: -Blood sugar (BS) range between 150-200 give 5 units. -BS range between 201-250 give 10 units.	D 358		

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D 358	Continued From page 14 -BS range between 251-300 give 15 units. -BS range between 301-350 give 18 units. -BS range between 351-400 give 20 units. -BS range between 401-450 give 25 units. -BS range 451 or above call doctor. Review of Resident #13's electronic Medication Administration Record (eMAR) for February 2017 revealed: -An entry for Novolog FlexPen check FSBS before each meal and inject per SSI: 150-200 = 5 units; 201-250 = 10 units; 251-300 = 15 units; 301-350 = 18 units; 351-400 = 20 units; 401-450 = 25 units; 451 or above call doctor beginning 02/26/17 was transcribed on the eMAR. -An entry for FSBS before meals was transcribed onto the MAR and scheduled at 8:00 am, 12:00 pm, and 5:00 pm. -FSBS results ranged from 170 to 357. Continued review of Resident #13's February eMAR revealed Novolog insulin per SSI was not documented for the amount administered for 4 out of 9 opportunities when sliding scale insulin should have been administered as follows: -On 02/27/17 at 5:00 pm, blood sugar result was 215 and 10 units of Novolog(SSI) should have been administered. None was documented as administered. -On 02/28/17 at 8:00 am, blood sugar result was 170 and 5 units of Novolog(SSI) should have been administered. None was documented as administered. -On 02/28/17 at 12:00 pm, blood sugar result was 267 and 15 units of Novolog(SSI) should have been administered. None was documented as administered. -On 02/28/17 at 5:00 pm, blood sugar result was 304 and 18 units of Novolog(SSI) should have been administered. None was documented as	D 358		

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D 358	Continued From page 15 administered. Review of Resident #13's eMAR for March 2017 revealed: -An entry for Novolog FlexPen check FSBS before each meal and inject per SSI: 150-200 = 5 units; 201-250 = 10 units; 251-300 = 15 units; 301-350 = 18 units; 351-400 = 20 units; 401-450 = 25 units; 451 or above call doctor beginning 02/26/17 was transcribed on the eMAR. -An entry for FSBS before meals was transcribed onto the MAR and scheduled at 8:00 am, 12:00 pm, and 5:00 pm. -FSBS values ranged from 210 to 350. -Novolog Insulin per SSI was not documented as amount administered for 22 of 29 opportunities when sliding scale insulin(SSI) should have been administered with examples as follows: -On 03/01/17 at 5:00 pm, blood sugar result was 251 and 10 units of Novolog(SSI) should have been administered. None was documented as administered. -On 03/02/17 at 12:00 pm, blood sugar result was 259 and 15 units of Novolog(SSI) should have been administered. None was documented as administered. -On 03/05/17 at 5:00 pm, blood sugar result was 350 and 18 units of Novolog(SSI) should have been administered. None was documented as administered. -On 03/06/17 at 5:00 pm, blood sugar result was 250 and 10 units of Novolog(SSI) should have been administered. None was documented as administered. -On 03/08/17 at 8:00 am, blood sugar result was 234 and 10 units of Novolog(SSI) should have been administered. None was documented as administered. Telephone interview on 03/13/17 at 10:52 am with	D 358		

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D 358	Continued From page 16 Resident #13's physician's office nurse revealed: -The physician had made recent changes to Resident #13's insulin and would be monitoring the FSBS values for expected changes. -The physician expected the facility to administer insulin as ordered and should be documenting the amount administered. -The physician's office had obtained a hemoglobin A1C (a measure of long term blood sugar levels with a value of 5.7 to 6.4 being the normal range and above 6.5 considered to be diabetic) on 12/30/16 and the result was 7.2. Interview on 03/13/17 at 11:45 am with Resident #13 revealed: -He had been a diabetic for many years. -He had not experienced any episodes of low blood sugar in a long time, his sugar mostly ran high. -His physician had changed his insulin administration about 3 weeks ago for him to receive sliding scale insulin (Novolog Flexpen) with each meal now instead once a day. -Staff routinely told him the FSBS value, but usually did not say how much insulin they were giving. Refer to interview on 03/09/17 at 9:40 am with a Medication Aide (MA). Refer to interview on 03/09/17 at 9:45 am with a second MA. Refer to interviews on 03/09/17 at 10:10 am and at 2:20 pm with the Director of Nursing (DON). Refer to interview on 03/09/17 at 10:00 am with a contracted Pharmacy Consultant. Refer to interview on 03/09/17 at 2:05 pm with the	D 358		

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D 358	Continued From page 17 Administrator. C. Review of Resident #14's current FL2 dated 01/26/17 revealed: -Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus and hypertension. -There were no insulin orders listed on the FL2. Review of Resident #14's Resident Register revealed an admission date of 08/03/15. Review of Resident #14's physician's orders dated 01/26/17 revealed an order for Novolin R sliding scale insulin (SSI) (Novolin R is a fast acting insulin used to decrease elevated blood sugar) to be given as needed for the fingerstick blood sugars (FSBS) checked daily at 6:00 am and 4:00 pm as follows: Blood sugar range less than 150 give 0 units. Blood sugar range between 150-200 give 2 units. Blood sugar range between 201-250 give 4 units. Blood sugar range between 251-300 give 6 units. Blood sugar range between 301-350 give 8 units. Blood sugar range between 301-350 give 8 units. Blood sugar range between 351-400 give 10 units. If over 400 call office or provider on call. Review of Resident #14's subsequent physician's orders dated 02/07/17 revealed an order for Novolin R SSI to be given as needed for the FSBS checked daily before each meal as follows: Blood sugar range less than 150 give 0 units. Blood sugar range between 150-200 give 2 units. Blood sugar range between 201-250 give 4 units. Blood sugar range between 251-300 give 6 units. Blood sugar range between 301-350 give 8 units. Blood sugar range between 301-350 give 8 units. Blood sugar range between 351-400 give 10	D 358		

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D 358	Continued From page 18 units. If over 400 call office or provider on call. Review of Resident #14's subsequent physician's orders dated 03/01/17 revealed an order for Novolin R to be given as needed for the FSBS checked daily before each meal as follows: Blood sugar range less than 150 give 0 units. Blood sugar range between 150-200 give 2 units. Blood sugar range between 201-250 give 4 units. Blood sugar range between 251-300 give 6 units. Blood sugar range between 301-350 give 8 units. Blood sugar range between 301-350 give 8 units. -There were no parameters as to when to call the physician. Review of Resident #14's Electronic Medication Administration Record (eMAR) for January 2017 revealed: -Resident #14 was hospitalized January 1-January 19, 2017 then again January 21-January 26, 2017 for a medical condition not related to the diagnosis of diabetes. -Check FSBS twice daily was transcribed onto the eMAR at 6:00 am and 4:00 pm. -Check FSBS before meals was transcribed onto the eMAR and documented at 6:00 am and 4:00 pm. -Insulin per SSI was not documented as administered correctly for 8 out of 10 doses documented. Examples were as follows: -On 01/27/17 at 7:30 am, blood sugar result was 178, no SSI was documented as administered, and should have been administered 2 units -On 01/28/17 at 7:30 am, blood sugar result was 238, no SSI was documented as administered, and should have been administered 4 units. -On 01/29/17 at 7:30 am, blood sugar result was 311, no SSI was documented as administered, and should have been administered 8 units.	D 358		

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D 358	Continued From page 19 -On 01/30/17 at 7:30 am, blood sugar result was 311, no SSI was documented as administered, and should have been administered 8 units. Review of Resident #14's eMAR for February 2017 revealed: -Check FSBS twice daily was transcribed onto the eMAR at 6:00 am and 4:00 pm, from 02/01/17 through 02/07/17. -Check FSBS before each meal was transcribed onto the MAR and documented as administered daily at 8:00 am, 12:00 pm, and 4:00 pm. -Insulin per SSI was not documented as administered for 102 out of 119 opportunities. Examples are as follows: -On 02/03/17 at 4:00 pm, blood sugar result was 387, no SSI was documented as administered, and should have been administered 8 units. -On 02/05/17 at 6:00 am, blood sugar result was 281, no SSI was documented as administered, and should have been administered 6 units. -On 02/06/17 at 4:00 pm, blood sugar result was 207, no SSI was documented as administered, and should have been administered 4 units. -On 02/26/17 at 4:00 pm, blood sugar result was 275, no SSI was documented as administered, and should have been administered 4 units. Interview on 03/09/17 at 3:30 pm with a Medication Aide (MA) revealed: -She administered insulin according to Resident #14's sliding scale order, but was not sure how to document the insulin administration because there was no space to document it on the eMARs. -She had not reported this to anyone. Interview on 03/09/17 at 4:00 pm with another MA revealed: -She administered insulin according to the sliding	D 358		

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D 358	Continued From page 20 scale ordered for Resident #14. -Not every resident had a space on the eMAR to document the insulin administered. -She had not reported this to anyone. Interview on 03/13/17 at 11:30 am with Resident #14 revealed: -"They check my sugar a lot". -The MA took her blood sugar and gave the resident insulin if she needed it. -"I get a shot if it's high". -She felt like she got the insulin she needed. Telephone interview on 03/13/17 at 10:50 am with a representative from Resident #14's physician's office revealed: -The physician was in the facility "a lot" and in frequent contact with Resident #14. -Resident #14 was seen by the physician in the facility and in the office as needed. -The physician reviewed the eMARs when he saw Resident #14 in the facility. -The physician felt the insulin had been administered as ordered to Resident #14. -The physician was very pleased with the care given to Resident #14 at the facility. Refer to interview on 03/09/17 at 9:40 am with a MA. Refer to interview on 03/09/17 at 9:45 am with a second MA. Refer to interviews on 03/09/17 at 10:10 am and at 2:20 pm with the Director of Nursing (DON). Refer to interview on 03/09/17 at 10:00 am with a contracted Pharmacy Consultant. Refer to interview on 03/09/17 at 2:05 pm with the	D 358		

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D 358	Continued From page 21 Administrator. Interview on 03/09/17 at 9:40 am with a medication aide (MA) revealed: -She was knowledgeable about sliding scale insulin and how to administer insulin according to the sliding scale. -She administered the sliding scale according to residents' blood sugar results, but was not sure how to document the insulin administration because there was no space to document on the eMARs. -She did not know where or how to document on the MARs for the quantity of insulin administered because there was no space to document. -She is not aware of any eMAR reviews done to check for accuracy and completeness. -"All boxes are to be filled in on the eMAR", so if there is no place to document, then you can't. Interview on 03/09/17 at 9:45 am with a second MA revealed: -She was knowledgeable about sliding scale insulin and how to administer insulin according to the sliding scale. -She administered insulin according to the sliding scale as ordered related to residents' blood sugar results, but was not sure how to document the insulin administration if there was no space to write it on the MARs in some cases and did not report it. -She did not know where or how to document on the eMARs for the quantity of insulin administered because there was no space to write it on. -She was not aware of any eMAR reviews done to check for accuracy and completeness. -"All boxes are to be filled in on the eMAR", so if there is no place to document, then you can't. -She knew to call the doctor for the residents that had an order to call the doctor for BS results with	D 358		

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D 358	Continued From page 22 parameters. Interview on 03/09/17 at 10:10 am and at 2:20 pm with the Director of Nursing (DON) revealed: -She completed initial training with staff as well as annual training on diabetes which included administration and documentation of insulin per sliding scale. -She provided a policy for common sites used for insulin injections and different types of insulin. -She had no written policy for insulin administration per sliding scale. -She was aware that the eMAR in some cases did not have the areas to document all of the necessary information pertaining to sliding scale insulin (SSI) and there were extra steps to take to document a note. -The contract pharmacy did all of our eMAR entries for the facility and set up the eMAR's for documentation by the MAs. -She was not aware that staff were not documenting blood sugars, if they were administering insulin, how much insulin they were administering or what injection site they utilized to administer the insulin. -"There are no reviews of the eMARs before the new month comes out for accuracy or new orders". -"There are no reviews of the eMARs at the end of the month for accuracy or holes". Interview on 03/09/17 at 10:00 am with a contracted Pharmacy Consultant revealed: -"The order entry is done by the pharmacy on all orders". -She was not aware of why the orders were set up the way they were in the eMARs, leaving out a space to document SSI amount and site on some residents' eMARs with SSI orders and not others. -The facility had not made them aware of the	D 358		

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D 358	Continued From page 23 documentation issues and were not noticed on the pharmacy reviews. -She was responsible for making sure the eMARs were correct in containing new orders and any other concerns. -She brought the documentation issue to the Quality Improvement person at the pharmacy after our interview was over. -She did not review for accuracy of SSI in regards to no blank spaces on the eMAR.. Interview on 03/09/17 at 2:05 pm with the Administrator revealed: -It was his expectation the facility follow the doctors' orders and document appropriately to show the work was done. -He felt that "the pharmacy consultant should have found the error on the eMAR" as they reviewed the eMARs and records. -The MAs should have let the DON know about the missing documentation areas for sliding scale insulin (SSI). The facility failed to assure insulin was administered as ordered by a licensed prescribing practitioner for Residents #3, #13, and #14 (with diagnoses including diabetes). This failure of not receiving sliding scale insulin as ordered can result in failure to treat diseases properly or exacerbations of clinical symptoms which was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a Plan of Protection on 03/10/17 as follows: -Staff will be trained and educated on medication administration policy including insulin (sliding scale) immediately. Review records for medication orders to verify medication orders match eMAR. All insulin orders in eMAR have	D 358		

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D 358	Continued From page 24 been corrected for entries to show number of units administered and site given. Staff will document on sliding scale insulin form blood sugar reading, number of units, site, and initials of who insulin dose was verified with. Regularly scheduled insulin doses will be verified by 2 Med Techs also and documented. Pharmacy contacted 03/10/17 and will correct and pharmacy end issues immediately. -The eMAR will be checked monthly to ensure all medications, including insulin and blood sugar readings, doses, and sites are documented. Continual communication with pharmacy will be done to correct any issues that are found. DON, ARCC, SCUC will go through records and monitor daily and then monitor all new orders for 3 weeks. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 27, 2017	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration;	D 367	Pharmacy set-up the eMAR and entered orders from physicians, pharmacy consultant present 3/8/17 & 3/9/17 for review and did not report any missed documentation. See notes from interview with pharmacy consultant in left hand column. See attached letter from Southern Pharmacy. Sliding Scale Insulin log in place for Med-tech to document amount administered and 2 Med-techs to sign off.	4/12/2017

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D 367	Continued From page 25 (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to assure the electronic Medication Administration Records (eMARS) were accurate for 2 of 4 sampled residents regarding sliding scale insulin (SSI) Novolin R (#12), and SSI Lantus (#13). The findings are: A. Review of Resident #13's current FL2 dated 11/08/16 revealed: -Diagnoses included coronary artery disease and diabetes. -An order for Lantus (a long acting insulin) insulin 30 units subcutaneously each night. Review of Resident #13's record revealed a physician's order dated 12/30/16 for Lantus check finger stick blood sugar (FSBS) at bedtime and inject per SSI according to the following parameters: -Blood sugar range between 130-159 give 20 units. -Blood sugar range between 160-199 give 30 units. -Blood sugar range greater than 200 give 40 units. Review of Resident #13's electronic Medication Administration Record (eMAR) for Lantus insulin	D 367		

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D 367	Continued From page 26 in January 2017 revealed: -An entry to check FSBS at bedtime and inject per SSI: Blood sugar(BS) 130-159 = 20 units, BS 160-199 = 30 units, and BS greater than 200 give 40 units was listed and scheduled for administration at 10:00 pm daily. -The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, and a space for documenting FSBS value, but no space for documenting the amount of Lantus administered. -FSBS values were documented 31 of 31 opportunities with a range from 215 to 370. -Lantus insulin should have been administered each day for 40 units based on the sliding scale parameters and nightly blood sugar values documented from 215 to 370. -There was no documentation for the amount of Lantus administered on the January 2017 eMAR. Interview on 03/09/17 at 11:30 am with the Director of Nursing (DON) revealed: -The medication aides (MAs) documented the administration of medications on the eMAR routinely. -The eMAR system also had a an option to add notes for medication administration and the notes appeared on an Administration History report that the facility could access and print. -The MAs could use the notes field to document administration of a medication if no other place to document was available on the eMAR. Review of the printed "Administration History" notes from 01/01/17 to 01/31/17 for Resident #13's Lantus revealed: -FSBS values were listed for 31 days in January 2017 and were consistent with values documented on Resident #13's eMAR. -On 01/01/17, 01/05//17, 01/08/17, and 01/16/17,	D 367		

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D 367	Continued From page 27 forty (40) units of Lantus was documented in the notes as administered. -Resident #13 had documentation of Lantus insulin administration for 4 of 31 opportunities. -The amount of sliding scale Lantus was not documented for 27 of 31 opportunities. Review of Resident #13's February 2017 eMAR for Lantus insulin revealed: -An entry to check finger stick blood sugar (FSBS) at bedtime and inject per SSI: Blood sugar(BS) 130-159 = 20 units, BS 160-199 = 30 units, and BS greater than 200 give 40 units was listed and scheduled for administration at 10:00 pm daily. -The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, and a space for documenting FSBS value, but no space for documenting the amount of Lantus administered. -FSBS values were documented 27 of 28 opportunities. -On 02/01/17, the FSBS was 178 and Resident #13 should have received 30 units of Lantus insulin; no Lantus insulin was documented as administered. -From 02/02/17 to 02/28/17, FSBS values ranged from 212 to 361 and Resident #13 should have received 40 units of Lantus insulin each night. -There was no documentation for the amount of Lantus administered on the February 2017 eMAR. Review of the printed "Administration History" notes from 02/01/17 to 02/28/17 for Resident #13's Lantus revealed: -FSBS values were listed for 28 days in February 2017 and were consistent with values documented on Resident #13's eMAR. -Resident #13 had no notes or documentation for	D 367		

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D 367	Continued From page 28 the amount of Lantus insulin administered for 28 of 28 opportunities. Examples of Resident #13's FSBS values documented on the February 2017 eMAR and "Administration History" notes but not documentation for the amount of Lantus administered were as follows: -On 02/02/17, FSBS was 351 and 40 units of Lantus should have been administered but no Lantus insulin was listed in the notes or on the eMAR as administered. -On 02/14/17, FSBS was 231 and 40 units of Lantus should have been administered but no Lantus insulin was listed in the notes or on the eMAR as administered. -On 02/20/17, FSBS was 219 and 40 units of Lantus should have been administered but no Lantus insulin was listed in the notes or on the eMAR as administered. -On 02/28/17, FSBS was 304 and 40 units of Lantus should have been administered but no Lantus insulin was listed in the notes or on the eMAR as administered. Review of Resident #13's eMAR for Lantus insulin in March 2017 revealed: -Check finger stick blood sugar (FSBS) at bedtime and inject per SSI: Blood sugar(BS) 130-159 = 20 units, BS 160-199 = 30 units, and BS greater than 200 give 40 units was listed and scheduled for administration at 10:00 pm daily. -The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, and a space for documenting FSBS value, but no space for documenting the amount of Lantus administered. -FSBS values were documented 9 of 9 scheduled opportunities from 03/01/17 to 03/09/17. -From 03/01/17 to 03/09/17, FSBS values ranged	D 367		

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D 367	Continued From page 29 from 213 to 381 and Resident #13 should have received 40 units of Lantus insulin each night. -The amount of Lantus insulin administered was not documented from 03/01/17 to 03/09/17. Review of the printed "Administration History" notes 01/01/17 to 03/09/17 for Resident #13's Lantus revealed: -FSBS values were listed for 9 days in March 2017 and were consistent with values documented on Resident #13's eMAR. -Resident #13 had documentation of Lantus insulin for 1 of 9 opportunities; on 03/03/17, FSBS was 282 and 40 units of Lantus was listed in the notes as administered. -There was no additional notes for the amount of Lantus administered for March 2017. Interview on 3/10/17 at 4:15 pm with an evening shift medication aide (MA) revealed; -She recorded the FSBS value and signed off for the administration of Lantus. -She administered the amount of sliding scale Lantus according to the parameters on the eMAR. -She did not document the amount of sliding scale Lantus but the resident received 40 units most of the time. -She had not reported to administrative staff that the eMAR did not have a place to document the amount of sliding scale Lantus. Interview on 03/10/17 at 4:18 pm with the evening shift Supervisor revealed: -The MAs administer Resident #13's Lantus each night. -The resident has parameters for the amount of Lantus to be administered according to the FSBS value obtained. -Resident #13 usually received 40 units of Lantus	D 367		

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D 367	Continued From page 30 because his blood sugar was over 200 most evenings. -She thought MA staff were documenting the amount of Lantus in the administration notes. -She was not able to provide any additional documentation for the amount of Lantus administered to Resident #13 from the notes. Interview on 03/13/17 at 11:45 am with Resident #13 revealed: -He had been a diabetic for many years. -He received Lantus insulin at night by the facility Medication Aides (MAs). -The MAs did not tell him how much Lantus insulin he was receiving each night. -He had not experienced any episodes of low blood sugar in a long time, his sugar mostly ran high. Refer to interview on 03/09/17 at 9:40 am with a Medication Aide (MA). Refer to interview on 03/09/17 at 9:45 am with a second MA. Refer to interviews on 03/09/17 at 10:10 am and at 2:20 pm with the Director of Nursing (DON). Refer to interview on 03/09/17 at 10:00 am with a contracted Pharmacy Consultant. Refer to interview on 03/09/17 at 2:05 pm with the Administrator. B. Review of Resident #12's current FL2 dated 05/25/16 revealed: -Diagnoses included respiratory insufficiency, diabetes mellitus, dehydration, hypothyroidism, and history of pneumonia.	D 367		

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D 367	Continued From page 31 Review of Resident #12's physician's orders dated 11/29/16 revealed an order to check finger stick blood sugar (FSBS) twice a day and to call if greater than 400. Review of Resident #12's physician's orders dated 11/30/16 revealed an order for Novolin R (Novolin R is a fast acting insulin used to decrease elevated blood sugars) Sliding Scale Insulin (SSI) twice a daily as follows: -Blood sugar range between 151-200 give 2 units. -Blood sugar range between 201-250 give 4 units. -Blood sugar range between 251-300 give 6 units. -Blood sugar range between 301-350 give 8 units. -Blood sugar greater than 350 give 10 units. Review of Resident #12's electronic Medication Administration Record (eMAR) for January 2017 revealed: -An entry for FSBS twice a day and scheduled for 8:00 am and 4:00 pm. -BS ranged from 139-485. -An entry for Novolin R SSI twice a day scheduled for administration at 8:00 am and 5:00 pm. -On 01/06/17 at 4:00 pm BS result was 411 and no SSI documented as administered. Staff documented BS of 411 on the eMAR in the area designated to document the amount of SSI given. -On 01/08/17 at 4:00 pm BS result was 482 and no SSI documented as administered. Staff documented BS of 482 on the eMAR in the area designated for the amount of SSI given. -On 01/21/17 at 4:00 pm BS result was 301, no SSI was documented as administered, and should have received 8 units. Staff documented BS of 301 on the eMAR in the area designated for the amount of SSI given. -On 01/25/17 at 4:00 pm BS result was 258, no SSI was documented as administered, and should have received 6 units. Staff documented	D 367		

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D 367	Continued From page 32 BS of 258 on the eMAR in the area designated for the amount of SSI given. -On 01/26/17 at 4:00 pm BS result was 162, no SSI documented as administered, and should have received 2 units. Staff documented BS of 162 on the eMAR in the area designated for the amount of SSI given. -On 01/31/17 at 4:00 pm BS result was 367, no SSI documented as administered, and should have received 10 units. Staff documented BS of 367 on the eMAR in the area designated for the amount of SSI given. Review of Resident #12's eMAR for February 2017 revealed: -Am entry for FSBS twice a day and scheduled for 8:00 am and 5:00 pm. -BS ranged from 148-357. -An entry for Novolin R SSI twice a day scheduled for administration at 8:00 am and 5:00 pm. --On 02/11/17 at 5:00 pm BS result was 331, no SSI documented as administered, and should have received 8 units. Staff documented BS of 331 on the eMAR in the area designated for the amount of SSI given. -On 02/21/17 at 5:00 pm BS result was 244, no SSI documented as administered, and should have received 4 units. Staff documented BS of 244 on the eMAR in the area designated for the amount of SSI given -On 02/22/17 at 5:00 pm BS result was 234, no SSI documented as administered, and should have received 4 units. Staff documented BS of 234 on the eMAR in the area designated for the amount of SSI given. -On 02/27/17 at 5:00 pm BS result was 326, no SSI documented as administered, and should have received 8 units. Staff documented BS of 326 on the eMAR in the area designated for the amount of SSI given.	D 367		

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D 367	Continued From page 33 Review of Resident #12's eMAR for March 1 at 8:00 am - March 10, at 12:00 pm 2017 revealed: -An entry for FSBS twice a day and scheduled for 8:00 am and 5:00 pm. -BS ranged from 208-293. -An entry for Novolin R SSI twice a day scheduled for administration at 8:00 am and 5:00 pm. -On 03/02/17 at 5:00 pm BS result was 275, no SSI documented as administered, and should have received 6 units. Staff documented BS of 275 on the eMAR in the area designated for the amount of SSI given. -On 03/04/17 at 5:00 pm BS result was 339, no SSI documented as administered, and should have received 8 units. Staff documented BS result of 389 on the eMAR in the area designated for the amount of SSI given. Interview on 03/13/17 at 9:45 am with Medication Aide revealed she understood to document the amount of insulin in the area designated for the insulin and the BS in the area designated for the BS. Interview on 03/13/17 at 10:00 am with the Director of Nursing revealed: -Medication aids were aware that insulin should be documented in area on eMAR designated for insulin given. -She was not aware that BS were being documented in the area designated for the amount of insulin administered. Refer to interview on 03/09/17 at 9:40 am with a Medication Aide (MA). Refer to interview on 03/09/17 at 9:45 am with a second MA.	D 367		

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D 367	Continued From page 34 Refer to interviews on 03/09/17 at 10:10 am and at 2:20 pm with the Director of Nursing (DON). Refer to interview on 03/09/17 at 10:00 am with a contracted Pharmacy Consultant. Refer to interview on 03/09/17 at 2:05 pm with the Administrator. Interview on 03/09/17 at 9:40 am with a medication aide (MA) revealed: -She administered insulin according to the sliding scale according to residents' blood sugar results, but was not sure how to document the insulin administration because there was no space to document on the eMARs. -She did not know where or how to document on the MARs for the quantity of insulin administered because there was no space to document. -She is not aware of any eMAR reviews done to check for accuracy and completeness. -"All boxes are to be filled in on the eMAR", so if there is no place to document, then you can't. Interview on 03/09/17 at 9:45 am with a second MA revealed: -She administered insulin according to the sliding scale as ordered related to residents' blood sugar results, but was not sure how to document the insulin administration if there was no space to write it on the MARs in some cases and did not report it. -She did not know where or how to document on the eMARs for the quantity of insulin administered because there was no space to write it on. -She was not aware of any eMAR reviews done to check for accuracy and completeness. -"All boxes are to be filled in on the eMAR", so if there is no place to document, then you can't. -She knew to call the doctor for the residents that	D 367		

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D 367	Continued From page 35 had an order to call the doctor for BS results with parameters. Interview on 03/09/17 at 10:10 am and at 2:20 pm with the Director of Nursing (DON) revealed: -She completed initial training with staff as well as annual training on diabetes which included administration and documentation of insulin per sliding scale. -She was aware that the eMAR in some cases did not have the areas to document all of the necessary information pertaining to sliding scale insulin (SSI) and there were extra steps to take to document a note. -The contract pharmacy did all of our eMAR entries for the facility and set up the eMAR's for documentation by the MAs. -She was not aware that staff were not documenting blood sugars, if they were administering insulin, how much insulin they were administering or what injection site they utilized to administer the insulin. -"There are no reviews of the eMARs before the new month comes out for accuracy or new orders". -"There are no reviews of the eMARs at the end of the month for accuracy or holes". Interview on 03/09/17 at 10:00 am with a contracted Pharmacy Consultant revealed: -"The order entry is done by the pharmacy on all orders". -She was not aware of why the orders were set up the way they were in the eMARs, leaving out a space to document SSI amount and site on some residents' eMARs with SSI orders and not others. -The facility had not made them aware of the documentation issues and were not noticed on the pharmacy reviews. -She was responsible for making sure the eMARs	D 367		

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D 367	Continued From page 36 were correct in containing new orders and any other concerns. -She brought the documentation issue to the Quality Improvement person at the pharmacy after our interview was over. -She did not review for accuracy of SSI in regard to no blank spaces on the eMAR.. Interview on 03/09/17 at 2:05 pm with the Administrator revealed: -It was his expectation the facility follow the doctors' orders and document appropriately to show the work was done. -He felt that "the pharmacy consultant should have found the error on the eMAR" as they reviewed the eMARs and records. -The MAs should have let the DON know about the missing documentation areas for sliding scale insulin (SSI).	D 367		
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 observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to medication administration and infection prevention requirements.	D912	Staff has been retrained on diabetes, blood sugar parameters in place, and Sliding Scale Insulin log in place. DON and RCD's check weekly to ensure proper use of blood glucose meters. Addendum per telephone conversation on 4/25/17 at 11:38am with the Director of Nursing Sliding Scale Insulin Logs are checked once a month by the DON and RCD's.	4/12/17

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D912	Continued From page 37 The findings are: A. Based on observations, interviews, and record reviews, the facility failed to assure documentation of administration of medications as ordered by a licensed prescribing practitioner, which included errors with administration and omissions, for 3 of 4 residents ordered sliding scale insulin (SSI) of Novolin R (#3, #14), and SSI of Novolog FlexPen (#13). [Refer to Tag D 0358, 10A NCAC 13F. 1004(a) Medication Administration (Type B Violation).] B. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control regarding the sharing of glucometers between residents and proper disinfection of fingerstick blood sugar (FSBS) monitoring equipment for 4 of 6 sampled residents, (#2, #8, #10, and #11). [Refer to Tag D 0932, G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation).]	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection	D932		

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D932	Continued From page 38 control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on	D932	Facility, at no cost to the residents, supplied new blood glucose meters for all residents. Facility, at no cost to residents, will provide safety lancets and strips. Manufacturer of new machines was called to verify machines can be disinfected and cleaned. Staff retrained on how to properly clean and disinfect machines. Weekly verification of blood glucose values against eMAR will be done by RN and RCD's and documented.	4/12/17

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D932	Continued From page 39 infection control regarding the sharing of glucometers between residents and proper disinfection of fingerstick blood sugar (FSBS) monitoring equipment for 4 of 6 sampled residents, (#2, #8, #10, and #11). The findings are: Observation on 03/08/17 at 12:00 pm of the treatment carts and glucometer storage areas in the assisted living unit revealed: -There was a total of 17 glucometers that were stored in clear plastic zip-lock bags labeled with a resident's name. -The glucometers were manufactured by various companies. Observation on 03/08/17 at 4:00 pm of the treatment cart in the Special Care Unit (SCU) revealed: -There was a total of 4 glucometers that were stored in clear plastic zip-lock bags labeled with a resident's name. -The glucometers were manufactured by various companies. Interview with the Director of Nursing/Resident Care Director (RCD) on 03/08/17 at 4:30 pm revealed: - The facility had 18 residents receiving fingerstick blood sugar (FSBS) checks in the Assisted Living Unit (ALU) and 4 residents receiving fingerstick blood sugar checks in the SCU. - None of the residents receiving FSBS checks had a diagnosis of blood borne infectious disease such as hepatitis or Human Immunodeficiency Virus (HIV). Based on the Center for Disease Control (CDC)	D932		

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D932	Continued From page 40 guidelines for infection control, the recommendations were that blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list the disinfection information, the glucometer should not be shared between residents. Telephone interview on 03/08/17 at 4:30 pm with a representative from Brand A's glucometer customer service department revealed: -This glucometer could be used on more than one person if proper disinfection protocols were adhered to. -The protocol for proper disinfection required the use an Environmental Protection Agency (EPA) approved disinfectant wipe that was effective against blood borne pathogens and tuberculosis. (The disinfectant wipe should be used according to the directions of the manufacturer of the wipe.) Review of the Brand B's glucometer operation manual revealed the meter "is intended to be used by a single person and should not be shared." Telephone interview on 03/10/17 at 11:00 am with a representative from Brand C's glucometer customer service department revealed that Brand C was not intended for multi-patient use and there was no manufacturer's recommended cleaning or disinfecting instructions that would allow this machine to be used on multiple people. A. Review of Resident #11's current FL2 dated 01/17/17 revealed: -Diagnoses included diabetes mellitus. -An order for FSBS check three times a day,	D932		

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D932	Continued From page 41 before meals. Review of Resident #11's Resident Register revealed an admission date of 09/17/16. Observation of medication finger stick blood sugar testing on 03/08/17 at 11:30 am revealed: -The dayshift medication aide (MA) obtained a plastic zip-lock bag labeled with Resident #11's name from the medication cart. -The glucometer located inside the bag labeled with Resident #11's name was a Brand B glucometer and was not labeled with the resident's name. -The MA used a single use disposable lancing device to stick the resident's finger. -The medication cart had a supply of alcohol swabs and single use disposable lancing devices on the cart, but no EPA approved disinfecting wipes were available for use. -The MA checked Resident #11's FSBS with the glucometer and disposed of the strip, single use disposable lancing device and glucometer strip in the biohazard container located on the medication cart. -The MA was not observed cleaning or disinfecting the glucometer before or after obtaining the FSBS and returning the glucometer to the plastic storage bag. Review of Resident #11's February 2017 and March 2017 electronic Medication Administration Records (eMAR) revealed an entry for FSBS three times daily at 8:00 am, 12:00 pm, and 5:00 pm and documentation the FSBS were obtained as ordered. Review of the memory for the Brand B glucometer used for Resident #11 revealed: -The date and time was set correctly for the date,	D932		

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D932	Continued From page 42 but the time was one hour later than actual time. -The values in the glucometer's history were inconsistent with the values entered on the eMAR. Review of Resident #11's March 2017 eMAR compared to the glucometer's history revealed: -There were no FSBS values in the glucometer's history that matched FSBS values documented on the eMAR for 03/06/17 at 12:00 pm (FSBS=238) and 8:00 am (FSBS=168) -There were no FSBS values in the glucometer's history that matched FSBS values documented on the eMAR for 03/03/17 at 12:00 pm (FSBS=303) and 8:00 am (FSBS=153). -The FSBS result for 03/07/17 at 5:30 pm of 327 was not consistent with the result of 248 entered on the eMAR for 03/07/17 at 5:30 pm (FSBS=327). Review of Resident #11's February 2017 eMAR compared to the glucometer's history revealed: -The FSBS result for 02/25/17 at 5:20 pm of 241 was consistent with the result entered on the eMAR; there was one additional reading in the glucometer for 02/25/17 at 5:32 pm of 88 that did not match the documentation on Resident #11's eMAR. -The FSBS result for 02/25/17 at 12:49 pm of 247 was consistent with the result entered on the eMAR; there was one additional reading in the glucometer for 02/25/17 at 12:56 pm of 213 that did not match the documentation on Resident #11's eMAR Example of additional FSBSs documented on Resident #11's eMARs which did not appear in Resident #11's glucometer memory included: -FSBS 242 on 02/24/17 at 12:00 pm. -FSBS 148 on 02/24/17 at 8:00 am.	D932		

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D932	Continued From page 43 -FSBS 228 on 02/20/17 at 12:00 pm. -FSBS 154 on 02/20/17 at 8:00 am. Interview on 03/10/17 at 1:15 pm with Resident #11 revealed: -He thought the medication aide (MA) staff used the same glucometer on him most of the time for his FSBS checks. -There may have been a few times when staff used a different glucometer to check his FSBS because his glucometer might not have been working properly. -He did had not observed staff cleaning his glucometer before or after use. Refer to interview on 03/08/17 at 3:45 pm with the Director of Nursing (DON). Refer to interview on 03/08/17 at 4:25 pm with an evening shift MA. Refer to interview on 03/08/17 at 4:30 pm with a two additional evening shift MAs. Refer to interview on telephone interview on 03/09/17 at 10:10 am with a night shift MA. Refer to interview on 03/09/17 at 1:50 pm with two day shift MAs. Refer to interview on 03/09/17 at 2:05 pm with the Administrator. B. Review of Resident #2's current FL2 dated 02/27/17 revealed: -Diagnoses included diabetes mellitus Type 2. -An order for finger stick blood sugar (FSBS) checks three times a day, before meals. Review of Resident #2's Resident Register	D932		

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D932	Continued From page 44 revealed an admission date of 09/12/13. Review of Resident #2's February 2017 and March 2017 electronic Medication Administration Records (eMAR) revealed the FSBS was completed three times daily at 8:00 am, 12:00 pm, and 5:00 pm. Review of the Brand C glucometer used for Resident #2 revealed: -The clear plastic zip-lock bag, and the glucometer inside the bag were labeled with Resident #2's name. -The date and time was set correctly for the date, but the time was one hour later than actual time. -The values in the glucometer's history were inconsistent with the values entered on the eMAR. Review of Resident #2's March 2017 eMAR compared to the glucometer's history revealed: -There were no values in the glucometer's history for FSBS values documented on the eMAR for 03/06/17 at 12:00 pm (248) and 8:00 am (108). -The FSBS result for 03/03/17 at 2:12 pm of 251 was consistent with the value documented at 12:00 pm, but there was an additional FSBS of 303 at 12:57 pm recorded in the glucometer's history. Review of Resident #2's February 2017 eMAR compared to the glucometer's history revealed: -The FSBS result for 02/25/17 at 8:43 am of 127 was consistent with the result entered on the eMAR. -There were 2 additional readings in the glucometer for 02/25/17 at 8:29 am of 163 (Matching a FSBS value documented on Resident #11's eMAR for the corresponding time but not recorded in Resident #11's glucometer's	D932		

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D932	Continued From page 45 history), and at 8:48 am a reading of 270 that did not match the documentation on Resident #11's eMAR. -The FSBS result for 02/24/17 at 8:40 am of 123 was consistent with the result entered on the eMAR. -There were 2 additional readings in the glucometer for 02/24/17 at 8:33 am of 148, and at 8:44 am a reading of 281 that did not match the documentation on Resident #11's eMAR. Interview on 03/10/17 at 11:20 am with Resident #2 revealed: -Medication Aide (MA) staff checked the resident's FSBS routinely. -The resident thought there was a glucometer assigned to the resident. -The resident did not pay attention to the glucometer used to check FSBS, and was not able to identify the type of glucometer. Refer to interview on 03/08/17 at 3:45 pm with the Director of Nursing (DON). Refer to interview on 03/08/17 at 4:25 pm with an evening shift MA. Refer to interview on 03/08/17 at 4:30 pm with a two additional evening shift MAs. Refer to interview on telephone interview on 03/09/17 at 10:10 am with a night shift MA. Refer to interview on 03/09/17 at 1:50 pm with two day shift MAs. Refer to interview on 03/09/17 at 2:05 pm with the Administrator. C. Review of Resident #10's current FL2 dated	D932		

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D932	Continued From page 46 07/11/16 revealed: -Diagnoses included diabetes mellitus Type 2. -An order for finger stick blood sugar (FSBS) check once daily. Review of Resident #10's Resident Register revealed an admission date of 04/02/13. Review of Resident #10's record revealed a signed physician order dated 10/03/16 for FSBS checks once daily. Review of Resident #10's February 2017 and March 2017 electronic Medication Administration Records (eMAR) revealed an entry for FSBS daily at 6:00 am. Review of the Brand A glucometer used for Resident #10 revealed: -The clear plastic zip-lock bag, and the glucometer inside the bag were labeled with Resident #10's name. -The date and time was not set correctly. (The date and time displayed on the glucometer was 05/03 at 10:27 pm on 03/08/17 at 1:00 pm.) -The values in the glucometer's history were inconsistent with the values entered on the eMAR. Review of Resident #10's March 2017 eMAR compared to the glucometer's history revealed: -The FSBS result for 03/06/17 at 6:00 am of 112 was consistent with the value documented on the resident's eMAR at 6:00 am. -There were additional readings on 03/06/17 as follows: at 9:00 am FSBS of 168 (matching the FSBS value documented on Resident #11's eMAR and not recorded in Resident #11's glucometer's history), at 9:18 am FSBS of 108 (matching the FSBS value documented on	D932		

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D932	Continued From page 47 Resident #2's eMAR and not recorded in Resident #2's glucometer's history), at 9:23 am FSBS of 243, at 1:21 pm FSBS of 238 and at 1:27 pm FSBS of 248, recorded in the glucometer's history that did not match FSBS results documented on the eMAR. Review of Resident #10's February 2017 eMAR compared to the glucometer's history revealed: -The FSBS result for 02/20/17 at 5:42 am of 124 was consistent with the result entered on the eMAR. -There were additional readings on 02/20/17 as follows: at 8:09 am FSBS of 154, at 8:22 am FSBS of 263, at 9:20 am FSBS of 290, and at 9:27 am FSBS of 94, recorded in the glucometer's history that did not match FSBS results documented on the eMAR. Interview on 03/10/17 at 10:40 am with Resident #10 revealed: -The medication aide (MA) staff checked the resident's FSBS routinely. -The resident did not pay attention to the glucometer used to check FSBS, and was not able to identify the type of glucometer. Refer to interview on 03/08/17 at 3:45 pm with the Director of Nursing (DON). Refer to interview on 03/08/17 at 4:25 pm with an evening shift MA. Refer to interview on 03/08/17 at 4:30 pm with a two additional evening shift MAs. Refer to interview on telephone interview on 03/09/17 at 10:10 am with a night shift MA. Refer to interview on 03/09/17 at 1:50 pm with	D932		

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D932	Continued From page 48 two day shift MAs. Refer to interview on 03/09/17 at 2:05 pm with the Administrator. D. Review of Resident #8's current FL2 dated 07/13/16 revealed: -Diagnoses included diabetes mellitus Type 2. -An order for fingerstick blood sugar (FSBS) check three times a day, before meals. Review of Resident #8's Resident Register revealed an admission date of 07/18/16 to the special care unit. Review of Resident #8's record revealed a signed physician's order dated 02/06/17 to check FSBS two times a day. Review of Resident #8's March 2017 electronic Medication Administration Records (eMAR) revealed an entry for FSBS 2 times daily at 6:00 am and 5:00 pm. Review of the Brand B glucometer used for Resident #8 revealed: -The storage bag and the glucometer were labeled with Resident #8's name. -The date and time was set correctly for the date. -The values in the glucometer's history were inconsistent with the values entered on the eMAR. Review of Resident #8's March 2017 eMAR compared to the glucometer's history revealed: -The FSBS result for 03/06/17 at 6:29 am of 113 was consistent with the result of 113 entered on the eMAR for 03/06/17 at 6:00 am; an additional FSBS value was recorded in the glucometer's history at 6:35 am for 152 that did not match	D932		

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D932	Continued From page 49 FSBS results documented on the eMAR. -The FSBS result for 03/05/17 at 6:32 am of 107 was consistent with the result of 107 entered on the eMAR for 03/06/17 at 6:00 am; an additional FSBS value was recorded in the glucometer's history at 6:42 am for 147 that did not match FSBS results documented on the eMAR. Values documented on the March 2017 eMAR for Resident #8 which did not appear in Resident #8's glucometer memory were as follows: -On 03/03/17 at 4:30 pm, FSBS of 211 was documented on the eMAR but no corresponding FSBS value was in the glucometer's history. -On 03/02/17 at 4:30 pm, FSBS of 114 was documented on the eMAR but no corresponding FSBS value was in the glucometer's history. Based on record review, and observation of Resident #8 on 03/10/17, it was determined the resident was not interviewable. Refer to interview on 03/08/17 at 3:45 pm with the Director of Nursing (DON). Refer to interview on 03/08/17 at 4:25 pm with an evening shift Medication Aide (MA). Refer to interview on 03/08/17 at 4:30 pm with a two additional evening shift MAs. Refer to interview on telephone interview on 03/09/17 at 10:10 am with a night shift MA. Refer to interview on 03/09/17 at 1:50 pm with two day shift MAs. Refer to interview on 03/09/17 at 2:05 pm with the Administrator.	D932		

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D932	Continued From page 50 Interview on 03/08/17 at 3:45 pm with the Director of Nursing (DON) revealed: -The facility policy was for each resident to have an assigned glucometer and the glucometer was to be used on the assigned resident only. -MAs were trained during the medication cart orientation, to use only the assigned glucometer to check FSBS for a resident. -The residents' glucometers were cleaned and disinfected once a month on the 4th Thursday night, by a night shift MA, using an EPA approved cleaning and disinfecting wipe. -The EPA wipes were not stored on the medication cart but kept in a medication storage room on the front hall for use during the monthly cleaning. -The facility did not have a system in place to routinely audit the glucometers' history values compared to FSBS values documented on the corresponding residents' electronic Medication Administration Records (eMARs). -She had not been auditing the glucometer's history values because she did not know staff were sharing glucometers between residents. Interview on 03/08/17 at 4:25 pm with an evening shift MA revealed: -All residents had a glucometer assigned to be used on the resident. -The MA had not shared glucometers between residents. -The MA cleaned the glucometer after each use, wiping the end and face of the glucometer with an alcohol wipe. Interview on 03/08/17 at 4:30 pm with a two additional evening shift MAs revealed: -All residents had a glucometer assigned to be used on the resident. -The MAs had shared a glucometer between	D932		

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D932	Continued From page 51 residents on occasion because testing strips were not available from the supplier for the resident. -The MAs cleaned the glucometer used to test the FSBS with an alcohol wipe before and after using the glucometer on a resident other than the assigned resident. Telephone interview on 03/09/17 at 10:10 am with a night shift Medication Aide (MA) revealed: -The facility policy was for each resident to have a glucometer assigned to the resident and not to share the glucometer with other residents. -All residents had a glucometer assigned to be used on the resident. -She did not share glucometers between residents. -The night shift was responsible to clean and disinfect all glucometers once a month with the Environmental Protection Agency (EPA) approved disinfecting wipe per the instructions on the wipes container (using at least one wipe to wet the glucometer for 3 to 4 minutes and allowing to air dry). -The EPA approved disinfecting wipes were not routinely stored on the medication carts (stored in a medications storage room on the front hall of the Assisted Living Unit). -She routinely cleaned and disinfected the residents' glucometer on the 4th Thursday night of each month, during her shift. -She did not maintain a log for documenting the cleaning and disinfecting of the glucometers which included the type of glucometer, name of resident, and the time and date of the disinfection. -She was not aware of the manufacturer's recommendation for sharing of each glucometer type. Interview on 03/09/17 at 1:50 pm with two day	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076003	A. BUILDING: _____ B. WING _____	03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D932	Continued From page 52 shift MAs revealed: -All residents had a glucometer assigned to be used on the resident. -Neither MA had an occasion when they shared a glucometer between residents. -They were not aware of any MA sharing a glucometer between residents. -One MA used alcohol wipes to clean the glucometer, the test strip area before and after each use. -The other MA did not routinely use alcohol wipes to clean the glucometer before or after use. -They did not remember the date of the last training on infection prevention, but knew they had a training in the past. Interview on 03/09/17 at 2:05 pm with the Administrator revealed: -Each resident receiving FSBS checks should have a glucometer assigned to the resident for checking FSBS. -It was the responsibility of the DON (for the Assisted Living Unit) and the Memory Care Director (MCD) [for the Special Care Unit] to manage the administration of medications, including FSBS and glucometers. -The DON and MCD ordered glucometers and diabetic supplies. -He was aware diabetic test strips were occasionally a problem to order for some residents. -He was not aware MA staff were sharing glucometers between residents. The facility failed to implement infection control procedures consistent with the Centers for Disease Control and Prevention guideline for 4 residents (#2, #8, #10, and #11) regarding staff sharing glucometers between residents. The sharing of glucometers between residents put the	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D932	Continued From page 53 residents at risk of transmission of bloodborne pathogen diseases. The failure to properly disinfect and/or utilize a single glucometer for each resident was detrimental to the health and safety of the residents and constitutes a Type B Violation. A Plan of Protection was provided by the facility on 03/08/17 as follows: -All glucometer manufacturers will be contacted by the Director of Nursing (DON) to determine if the glucometers are multiple use and can be disinfected or if the glucometers needed to be replaced. -Immediately, all glucometers designated by the manufacturer for single person use were disposed, and others disinfected properly. New meters to replace ones that were disposed will be in the facility within one hour. -Prior to each shift the MAs will be re-educated and disciplinary action taken as needed. -Weekly verification of blood glucose values against eMARs will be done by the DON (RN), Special Care Unit Coordinator and the Resident Care Director and documented. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 27, 2017.	D932		