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D 000	Initial Comments The Adult Care Licensure Section conducted an Annual and a Follow-up survey on May 10 and 11, 2017.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to contact the physician for clarification of a medication order for 1 of 5 sampled residents (#1) with orders for Lantus insulin. The findings are: Review of Resident #1's current FL-2 dated 12/20/16 revealed: -Diagnoses included hypoglycemia and Diabetes Mellitus. -A physician's order to check finger stick blood sugar (FSBS) 4 times daily. -A physician's order to administer 14 units of	D 344		

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Lantus (a long acting insulin) insulin every night at bedtime. Hold if FSBS < (less than) 149.

Review Resident #1 physician's orders dated 03/17/17 revealed:
-Lantus insulin was listed and pre-printed as inject 14 units subcutaneously at bedtime. Hold if FSBS > (greater than) 149.
-The sheet was signed by the primary care provider (PCP) and dated 03/17/17.

Review of Resident #1's March 2017 electronic Medication Administration Record (eMAR) revealed:
-An entry for Lantus insulin inject 14 units subcutaneously at bedtime. Hold if FSBS > (greater than) 149.
-Lantus was scheduled at 8:00 pm daily.
-FSBS results ranged from 93 to 374 from 03/01/17 through 03/31/17.
-There were 13 FSBS results documented where FSBS results were less than 149.
-There were 7 times Lantus was documented as administered when the FSBS was less than 149 and 6 times when Lantus was documented as held for FSBS less than 149 documented on the exceptions to administration sheet.
-FSBS results on the morning (at 8:00 am) following the 7 times Lantus was administered for FSBS less than 149 ranged from 136 to 189.

Review of Resident #1's April 2017 eMAR revealed:
-An entry for Lantus insulin inject 14 units subcutaneously at bedtime. Hold if FSBS > (greater than) 149.
-Lantus was scheduled at 8:00 pm daily.
-FSBS results ranged from 99 to 206 from 04/01/17 through 04/30/17.
-There were 11 FSBS results documented where

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FSBS results were less than 149.
-There were 6 times Lantus was documented as administered when the FSBS was less than 149, and 5 times when Lantus was documented as held for FSBS less than 149 documented on the exceptions to administration sheet.
-FSBS results on the morning (at 8:00 am) following the 6 times Lantus was administered for FSBS less than 149 ranged from 101 to 204.

Review of Resident #1's May 2017 eMAR revealed:
-An entry for Lantus insulin inject 14 units subcutaneously at bedtime. Hold if FSBS > (greater than) 149.
-Lantus was scheduled at 8:00 pm daily.
-There were 9 FSBS results ranging from 93 to 374 from 04/01/17 through 04/09/17.
-There were 3 FSBS results documented where FSBS results were less than 149.
-There were 2 times Lantus was documented as administered when the FSBS result was less than 149 and 1 time when Lantus was documented as held for FSBS less than 149 on the exceptions to administration.
-FSBS results on the morning (at 8:00 am) following the 2 times Lantus was administered for FSBS less than 149 ranged from 98 to 137.

Interview on 05/11/17 at 3:30 pm with an evening shift medication aide (MA) revealed:
-She had previously worked the night shift (11:00 pm to 7:00 am).
-She had been working the evening shift (3:0 pm to 11:00 pm) for approximately 4 weeks.
-She administered Lantus insulin to Resident #1 during her shift.
-She gave Lantus insulin according to the order on the eMAR.
-She had training on the administration of various

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types of insulin (short acting and long acting) with the last year.
-She had administered Lantus insulin to Resident #1 when the FSBS was greater than 149 and less than 149.
-She had not notified the Resident Care Director (RCD) or administration that Resident #1's order to hold Lantus insulin for FSBS greater than 149 was unusual.

Telephone interview on 05/11/17 at 11:30 am with a pharmacist at the contract pharmacy revealed:
-The pharmacy was responsible for keying all routine medication orders onto the eMARs for the facility.
-The facility could enter emergency orders (like antibiotics).
-All new orders are flagged to be reviewed by the facility and approved.
-Medication orders show up on the eMAR when the pharmacy enters the orders.
-The medication orders are entered in a medical records section of the contract pharmacy and checked in the pharmacy processing area for accuracy and completeness.
-The order for Lantus insulin was entered incorrectly in the order entry area of the pharmacy and made it past the final check.
-The facility was responsible to verify the order and approve the order on the eMAR.
-The pharmacy had no documentation for the facility contacting the pharmacy regarding Resident #1's Lantus insulin.
-The pharmacy would make the correction on Resident #1's eMAR after contacting the facility.

Telephone interview on 05/11/17 at 3:00 pm with a representative at Resident #1's primary care physician's (PCP) office revealed:
-Resident #1's physician notes documented the

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resident's order for Lantus insulin was hold if FSBS was less than 149.
-The office had no documentation of the facility contacting the office for clarification of the Lantus dosage.

Interview on 05/11/17 at 3:45 pm with the RCD revealed:
-She had been working as the RCD for the facility for approximately 4 months.
-Medication aides had a class on administering insulin 02/15/17 which included the various types of insulin and onset of each type, and documentation on the eMAR.
-She had been auditing residents' record for medications and focusing on assuring the residents' medications orders were up to date and matched the orders on the eMAR.
-She had been auditing the eMARs for incomplete documentation (holes in documentation).
-She had audited several residents' records but she not gotten to Resident #1's record.
-She was not aware Resident #1's Lantus insulin was ordered for hold if FSBS was less than 149 on the FL-2 dated 12/20/16 and ordered for hold if the FSBS was greater than 149 on the medication renewal Physician's Orders dated 03/17/17.

Interview on 5/11/17 at 3:55 pm with a MA revealed:
-He worked all shifts as needed.
-He administered Resident #1's Lantus insulin when he worked the evening shift.
-He administered Resident #1's Lantus insulin when the FSBS reading was greater than 149 because it made since to administer insulin when the FSBS was high and hold if the FSBS was low.

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D 344	Continued From page 5 Interview on 05/11/17 at 4:05 pm with the Administrator revealed: -She had a recent change to the RCD position. -The RCD was responsible for assuring the residents received medications as ordered. -The RCD had audited a lot of the residents' records and was working with the contract pharmacy to make sure residents were receiving medications as ordered and that the eMARs were accurate. -The RCD had begun implementing audit tools to help prevent future oversights. Interview on 03/11/15 at 4:15 pm with Resident #1 revealed: -He was not sure what his Lantus order stated. -MA staff told him what his FSBS was when they obtained a FSBS. -He thought he received Lantus insulin about every night. -He would not allow staff to give him Lantus if his FSBS was less than 90. -He could not recall an instance recently when he felt his blood sugar was getting too low. -He had snacks and drinks in his room to consume if he felt his blood was dropping.	D 344		
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	D 367		

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D 367	Continued From page 6 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; (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 observations, interviews and record reviews, the facility failed to ensure the accuracy of the electronic Medication Administration Record for 1 of 5 residents (Resident #1) sampled residents. The findings are: Review of Resident #1's current FL-2 dated 12/20/16 revealed: -Diagnoses included peripheral vascular disease and transient ischemic attack (TIA). -An order for warfarin 7.5 mg on Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday and 10 mg on Sunday. (Warfarin is a blood thinner. [Warfarin is administered to maintain an International Normalized Ration (INR) therapeutic range of 2.0 to 3.0] Review Resident #1 record revealed physician's orders dated 03/30/17 documenting laboratory results for an INR of 3.5, and warfarin orders as follows: -On 03/30/17, hold warfarin. -On 04/01/17, administer warfarin 5.0 mg.	D 367		

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D 367	Continued From page 7 -On 04/02/17, administer warfarin 5.0 mg. -On 04/03/17, administer warfarin 7.5 mg. -On 04/04/17, administer warfarin 5.0 mg. -On 04/05/17, administer warfarin 7.5 mg. -On 04/06/17, administer warfarin 7.5 mg. -Recheck INR in one week (04/06/17). Continued review of Resident #1's record revealed: -Laboratory results dated 04/06/17 for an INR of 5.6 and orders to hold warfarin for 3 days, then restart. -Resident #1 refused warfarin the next 4 doses. -Laboratory results dated 04/13/17 documented an INR value of 1.4 and recheck in one week. -Resident #1 had documented refusal of warfarin administration for 7 of 17 times from 04/14/17 to 04/30/17. -Warfarin was discontinued by the PCP on 05/03/17. Review of Resident #1's April 2017 electronic medication administration record (eMAR) revealed: -Warfarin 7.5 mg was listed on the eMAR from 04/01/17 to 04/06/17. -Warfarin 5.0 mg was not listed on the eMAR from 04/01/17 to 04/06/17. -Warfarin 7.5 mg was documented as administered from 04/01/17 to 04/05/17. -Warfarin 5.0 mg was not documented as administered on 04/01/17, 04/02/17, and 04/04/17. Telephone interview on 05/11/17 at 11:30 am with a pharmacist at the contract pharmacy revealed: -The pharmacy was responsible for keying all routine medication orders onto the eMARs for the facility. -The facility was responsible to fax all orders	D 367		

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D 367	Continued From page 8 (FL-2s, prescription orders, orders on laboratory results, hospital discharge summaries, or any other medication orders) to the contract pharmacy for review or adding to the eMAR. -The facility had staff with the necessary computer access that could enter emergency orders (like antibiotics or changes to warfarin based on laboratory test). -Medication orders showed up on the eMAR when the pharmacy entered the orders. -The medication orders were entered in a medical records section of the contract pharmacy and checked in the pharmacy processing area for accuracy and completeness. -The facility was responsible to make changes to the eMAR if needed before an order was sent to the pharmacy. -The pharmacy had no documentation for receiving the warfarin order dated 03/30/17. Telephone interview on 05/11/17 at 3:00 pm with a representative at Resident #1's primary care physician's (PCP) office revealed: -The office had documentation of notification, reported by a local health agency nurse on 04/13/17, stating Resident #1 had not received warfarin as ordered from 04/01/17 to 04/06/17, and that Resident #1 was refusing warfarin from 04/06/17 to 04/13/17. -The physician documented discussion with Resident #1 regarding the importance of not refusing to take warfarin and dosing the warfarin based on the laboratory results. -The local health agency nurse, which was obtaining INR results, assisted the facility with tracking the resident's compliance with warfarin administration. Interview on 05/11/17 at 3:30 pm with an evening shift medication aide (MA) revealed:	D 367		

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-She administered resident's medications according to the eMAR.
-The MA staff did not enter orders on the eMAR, she thought the contract pharmacy entered all the orders.
-The Resident Care Director (RCD) was responsible for checking residents' orders for accuracy.
-If there was no entry for warfarin 5.0 mg on 04/01/17, 04/02/17, and 04/04/17, she would not have known to administer the medication.

Interview on 05/11/17 at 3:45 pm with the RCD revealed:
-She had been working as the RCD for approximately 4 months.
-The facility (the Administrator and the RCD) could enter medication orders on the eMAR, but she relied on the pharmacy to enter the current.
-She had been auditing residents' record for medications and focusing on assuring the residents' medications orders were up to date and matched the orders on the eMAR.
-At the time of the warfarin error, she had not gotten to auditing Resident #1's
-The facility was responsible for faxing all orders received to the contract pharmacy.
-She was aware Resident #1's warfarin was not administered correctly in early April because the local health agency nurse that obtained INR results for Resident #1 had pointed out the inaccuracy of the eMAR to her around 04/12/17.
-Resident #1 was not compliant with taking warfarin.
-She had worked with the local health nurse to assure Resident #1's physician was notified for refusing warfarin since the incident in early April.
-She did not check the eMAR and the 03/30/17 order for Resident #1's warfarin for addition to the eMAR. The order was overlooked.

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D 367	Continued From page 10 -She did not know why the order for warfarin dated 03/30/17 did not get put on the April 2017 eMAR correctly; the MAs would have administered the warfarin correctly if the eMAR was correct for dosage ordered. Interview on 5/11/17 at 3:55 pm with a MA revealed: -He worked all shifts as needed. -He administered Resident #1's warfarin according to the current order on the eMAR and documented any refusals on the eMAR. Interview on 05/11/17 at 4:05 pm with the Administrator revealed: -She had a recent change to the RCD position. -The RCD was responsible for assuring the residents received medications as ordered. -The RCD had audited a lot of the residents' records and was working with the contract pharmacy to make sure residents were receiving medications as ordered and that the eMARs were accurate. -The RCD had begun implementing audit tools to help prevent future oversights. Interview on 03/11/15 at 4:15 pm with Resident #1 revealed: -He was not taking the blood thinner (warfarin) any longer. -He was concerned that taking the blood thinner could cause him to have nose bleeds or if he got a cut, he would bleed too much. -He refused to take the blood thinner and was glad it was discontinued. -He would talk to his physician at his next appointment about trying something else if he needed a blood thinner.	D 367		