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
	HAL034087	A. BUILDING: _____ B. WING _____	R 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HEIGHTS SENIOR LIVING COMMUNITY	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on January 31, 2018 and February 1, 2018.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications in accordance with physician orders for 1 of 5 sampled residents (Resident #4) regarding receiving the wrong dose of Lantus insulin. The findings are: Review of Resident #4's current FL-2 dated 12/01/16 revealed: -Diagnoses included dementia, hypertension, and diabetes mellitus. -There was a physician's order for Lantus insulin (long acting insulin) administer 14 units at bedtime. Review of Resident #4's Resident Register revealed the resident was admitted to the facility	{D 358}	D358 → All MT/SIC's will follow the three step system that is already in place for new orders (See Attachment) (ongoing)	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robyn Jones — TITLE: Executive Director — (X6) DATE: 2-16-18

Reviewed and accepted. 2/28/18

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{D 358}	Continued From page 1 on 1/22/14. Review of Resident #4's subsequent Lantus insulin orders from his Endocrinologist revealed: -On 9/14/17, there was a physician order for Lantus insulin 50 units subcutaneously (SQ) at bedtime. -On 10/16/17, there was a signed physician's order for Lantus insulin 50 units SQ at bedtime. -On 10/23/17, there was a physician's order to decrease Lantus insulin to 45 units. -Physician's orders dated 11/3/17, 11/13/17, 11/30/17, 12/7/17, 12/19/17, 12/28/17 and 1/29/18 did document any change to Lantus insulin 45 units at bedtime. Review of Resident #4's record revealed the last laboratory value, dated 8/31/17, for hemoglobin A1C (Hgb A1C) was 6.6 with a normal range of 4.8 to 5.6 [Hgb A1C is a laboratory test used to evaluate the amount of glucose in the blood over a period of time (usually 1 to 3 months)]. Review of Resident #4's January 2018 Medication Administration Record (MAR) revealed: -A preprinted entry for Lantus insulin inject 50 units SQ at bedtime and scheduled for administration each night at 8:00 pm. -Lantus insulin 50 units was documented as administered daily from 1/09/18 to 1/31/18. Based on observation, record review and interviews on 1/31/18 and 2/01/18, it was determined Resident #4 was not interviewable. Interview on 2/01/18 at 11:00 am with the Special Care Unit Coordinator (SCUC) revealed: -She did not know Resident #4 had a physician's order dated 10/23/17 for Lantus insulin 45 units at	{D 358}	→ The RSD or designee will be reviewing new order forms for complete transcribing of new orders. The new order tracking form will be checked daily by the RSD or designee, and an initial will be placed by the RSD or designee on the order tracking form to ensure that it was transcribed onto the MAR's correctly. → The MAR's will be checked daily to ensure there is proper documentation by all MT's by the RSD and/or designee on an ongoing basis. (ongoing)	

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{D 358}	Continued From page 2 bedtime. -Routinely, medication orders were faxed to the contract pharmacy by the medication aide (MA) on duty when the order was received. -The MA was supposed to stamp the faxed order (with a red facility fax stamp), initial the stamp, place a copy of the order in the SCUC's new order box, and place the stamped copy in the residents' records. -The Lantus insulin order dated 10/23/17 was not stamped indicating the order had been faxed to the contract pharmacy. -Prior to 11/28/17, the lead medication aide was responsible for tracking residents' new orders for addition to the MAR and medication being sent from the pharmacy. -The SCUC previously reviewed a random sample of residents' records for medications ordered compare to medications transcribed on the MARs. The SCUC must have overlooked Resident #4's change from 50 units to 45 units of Lantus insulin when reviewing the record. -The facility had implemented a new order tracking system in response to the previous survey 11/28/17, that would assist in tracking new medication orders being added to the MAR and administered correctly. -None of Resident #4's subsequent orders from his Endocrinologist addressed Lantus insulin, therefore the SCUC did not realize the dose was not correct. Telephone interview on 2/10/18 at 11:39 am with a staff member at Resident #4's Endocrinologist's office revealed: -Resident #4 was followed by the Endocrinologist through faxed fingerstick blood sugar (FSBS) value results. -Resident #4's Lantus insulin was 50 units at bedtime on an order dated 9/14/17.	{D 358}		

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{D 358}	Continued From page 3 -Resident #4's Lantus insulin was changed to 45 units at bedtime on an order dated 10/23/17. -Resident #4's Lantus insulin had no subsequent changes since 45 units at bedtime on the order dated 10/23/17. -The Endocrinologist expected the facility to administer Lantus according to the most current order of 45 units at bedtime. -The staff member would inform the Endocrinologist that Resident #4 was not receiving 45 units of Lantus insulin at bedtime as ordered. Interview on 2/01/18 at 1:00 pm with a dayshift MA for the Special Care Unit (SCU) revealed: -Currently, the MA on duty when a physician's order was received was responsible to fax the order to the pharmacy, stamp the order faxed and initial the stamp, place the order in the resident's record, enter the order in the new order tracking book. A second MA verifies the order and MAR transcription, and a third shift MA did a third verification of the order and MAR transcription. -Previously, the lead MA was responsible to transcribe orders on the MAR and fax orders to the pharmacy. She did not know how the orders were double checked. Interview on 2/01/18 at 12:45 pm with a representative of the contract pharmacy revealed: -The facility was responsible to fax all physician's orders, FL2s, hospital discharges, laboratory test values, and orders for medications to the contract pharmacy. -The contract pharmacy used the faxed information to generate current MARs for residents. -The contract pharmacy received the physician's order, dated 9/14/17, for Resident #4's Lantus insulin 50 units at bedtime.	{D 358}		

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{D 358}	Continued From page 4 -The facility was responsible to notify the contract pharmacy when the facility had medication orders for residents that did not match the MARs in order for the contract pharmacy to maintain current MARs for the residents. -The contract pharmacy hjad no record of receiving the Lantus insulin order dated 10/23/17 to decrease Lantus insulin to 45 units at bedtime. Interview on 2/01/18 at 2:10 pm with the Administrator revealed: -The SCUC was responsible for monitoring and assuring medications were administered as ordered. -Since 11/28/17, the facility had implemented a new order tracking system for monitoring medications orders compared to MARs and ensuring medications were administered as ordered. -Resident #4's order change from 50 units of Lantus insulin at bedtime to 45 units of Lantus insulin at bedtime was not caught on the review. On 2/10/18 at 2:30 pm the SCUC presented a copy of a faxed physician's order, from Resident #4's Endocrinologist, dated 2/1/18 at 12:30 pm for Resident #4's Lantus insulin 50 units at bedtime. Based on observation, interview, and record review, Resident #4 received Lantus insulin 50 units at bedtime from 1/9/18 to 1/31/18 and should have been receiving Lantus insulin 45 units at bedtime.	{D 358}		