STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL059033	A. BUILDING: _____ B. WING _____	R 06/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSTON HOUSE	9460 HWY 64 UNION MILLS, NC 28167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the McDowell County Department of Social Services conducted an annual survey on June 5 - 6, 2018.	D 000		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: The facility failed to assure medications were administered in accordance with infection control measures during the medication pass for 2 of 2 residents with physician's orders for Novolog insulin (Resident #7 and #8), and 2 of 3 sampled residents with physician's orders for Victoza (Resident #1) and Novolin 70/30 insulin (Resident #2). The findings are: 1. Review of Resident #8's FL2 dated 05/23/18 revealed: -A diagnosis of insulin dependent diabetes. -There was an order for a Novolog FlexPen (an injectable insulin used to treat high blood sugar) 100 units/ml inject 6 units at 8:00am, 12:00pm and 4:00pm, hold if blood sugar is less than 100. -There was an order for sliding scale Novolog insulin with the following parameters: FSBS readings of 151-200 = 2 units of insulin; 201-250 = 3 units; 251-300 = 5 units; 301-350 = 8 units;	D 371		

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D 371	Continued From page 1 351-400 = 10 units; 401-450 = 12 units; 451-500 = 15 units; blood sugar greater than 500 after 15 units of insulin administered, call the Nurse Practitioner (NP). Observation of the medication pass with the medication aide (MA) on 06/05/18 at 11:21am revealed: -There was an entry on the Medication Administration Record (MAR) for 6 units of Novolog 100units/ml insulin to be administered. -Upon further investigation the Novolog FlexPen, identified with Resident #8's name, was not labeled with the opened-on date. Observation of Resident #8's medications on hand on 06/05/18 at 11:45am revealed a Novolog FlexPen 100 units/ml had no opened-on date documented. Review of Resident #8's insulin pens on 06/05/18 revealed the medication label for the Novolog FlexPen had a dispensed date of 04/04/18. Review of Resident #8's MARs for May and June 2018 revealed Resident #8 received Novolog FlexPen 100units/ml, inject 6 units at 8am, 12pm, and 4pm, and Novolog sliding scale insulin as ordered. Review of the Novolog FlexPen medication guide revealed the insulin is stable once opened at room temperature (up to 86 degrees Fahrenheit) for 28 days. Refer to observation of diabetic medications and supplies stored in the medication room on 06/05/18 at 11:45am. Refer to interview with the Resident Care	D 371		

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Coordinator (RCC) on 06/06/18 at 10:15am.

Refer to interview with MA on 06/06/18 at 10:30am.

Refer to interview with the Pharmacist on 06/06/18 at 1:47pm.

Refer to interview with the Manager on 06/06/18 at 1:55pm.

Refer to interview with the RCC on 06/06/18 at 2:05pm.

Refer to attempted telephone interview with the NP on 06/06/2018 at 2:58pm.

2. Review of Resident #7's current FL2 dated 02/28/18 revealed:
-A diagnosis of diabetes mellitus type 2.
-An order for Novolog Flexpen (an injectable insulin used to treat high blood sugar) 100units/ml sliding scale: 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, if over 400 call the NP on duty.
-An order for Novolog Flexpen 100units/ml, inject 6 units at 11am and 4pm, hold if blood sugar is less than 120.

Observation of Resident #7's medications on hand on 06/05/18 at 11:45am revealed a Novolog Flexpen that had no opened-on date.

Review of Resident #7's medication label revealed a Novolog Flexpen with a dispensed date of 2/26/18.

Review of Resident #7's MARs for May and June 2018 revealed Resident #7 received Novolog

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D 371	Continued From page 3 Flexpen 100units/ml, inject 6 units twice daily at 11am and 4pm, and Novolog sliding scale insulin as ordered. Review of the Novolog FlexPen medication guide revealed the insulin is stable once opened at room temperature (up to 86 degrees Fahrenheit) for 28 days. Refer to observation of diabetic medications and supplies stored in the medication room on 06/05/18 at 11:45am. Refer to interview with the RCC on 06/06/18 at 10:15am. Refer to interview with MA on 06/06/18 at 10:30am. Refer to interview with the Pharmacist on 06/06/18 at 1:47pm. Refer to interview with the Manager on 06/06/18 at 1:55pm. Refer to interview with the RCC on 06/06/18 at 2:05pm. Refer to attempted telephone interview with the NP on 06/06/2018 at 2:58pm. 3. Review of Resident #1's current FL2 dated 04/16/18 revealed an order for Victoza (a once-daily non-insulin injectable medicine that lowers blood sugar and A1C) 18mg/3ml inject 1.2mg once daily. Review of Resident #1's hospital discharge summary dated 04/16/18 revealed a diagnosis of diabetes mellitus type 2.	D 371		

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D 371	Continued From page 4 Observation of Resident #1's medications on hand on 06/05/18 at 11:45am revealed a Victoza injectable pen that had no opened-on date. Review of Resident #1's medication label for Victoza revealed a dispensed date of 03/12/18. Review of Resident #1's MARs for May and June 2018 revealed Resident #1 received Victoza as ordered. Review of the Victoza Medication Guide revealed: -After initial use of the Victoza pen, the pen can be stored for 30 days at controlled room temperature (59°F to 86°F) or in a refrigerator (36°F to 46°F). -Use a Victoza pen for only 30 days. -Throw away a used Victoza pen after 30 days, even if some medicine is left in the pen. Refer to observation of diabetic medications and supplies stored in the medication room on 06/05/18 at 11:45am. Refer to interview with the RCC on 06/06/18 at 10:15am. Refer to interview with the MA on 06/06/18 at 10:30am. Refer to interview with the Pharmacist on 06/06/18 at 1:47pm. Refer to interview with the Manager on 06/06/18 at 1:55pm. Refer to interview with the RCC on 06/06/18 at 2:05pm.	D 371		

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Refer to attempted telephone interview with the NP on 06/06/2018 at 2:58pm.

4. Review of Resident #2's current FL2 dated 04/18/18 revealed:
-A diagnosis of diabetes mellitus type 2.
-There was an order for Novolin 70/30 (an injectable medication used control high blood sugar in patients with diabetes mellitus) 100units/ml insulin, inject 5 units twice daily.

Observation of Resident #2's medications on hand on 06/05/18 at 11:49am revealed:
-There was a Novolin 70/30 100units/ml vial, inject 5 units twice daily, available for administration.
-The insulin vial was in the refridgerator in the medication room and had no opened-on date.

Review of Resident #2's medication label for the Novolin 70/30 insulin vial had a dispensed date of 04/24/18.

Review of Resident #2's MARs for May and June 2018 revealed Resident #2 received Novolin 70/30 as ordered.

Review of the Novolin 70/30 insulin medication guide revealed:
-The in use vial may be kept at room temperature (below 86 degrees Fahrenheit) for 28 days.
-The insulin should be discarded after 28 days.

Refer to observation of diabetic medications and supplies stored in the medication room on 06/05/18 at 11:45am.

Refer to interview with the RCC on 06/06/18 at 10:15am.

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D 371	Continued From page 6 Refer to interview with the MA on 06/06/18 at 10:30am. Refer to interview with the Pharmacist on 06/06/18 at 1:47pm. Refer to interview with the Manager on 06/06/18 at 1:55pm. Refer to interview with the RCC on 06/06/18 at 2:05pm. Refer to attempted telephone interview with the NP on 06/06/2018 at 2:58pm. _____ Observation of diabetic medications and supplies stored in the medication room on 06/05/18 at 11:45am revealed: -Diabetic supplies were stored in a plastic container on the countertop in the medication room. -There were 5 drawers in each container and each drawer was labeled with the resident's name. -Each drawer contained a glucometer, glucometer case, lancing device, needles and test strips. -Diabetic injectable medication pens were kept in the drawers along with supplies. -Insulin vials were kept in the refrigerator. Interview with the RCC on 06/06/18 at 10:15am revealed: -She thought the medication in the flexpens, Victoza pen, and the vial expired after 45-60 days. -She interpreted the manufacturer's expiration date, stamped on the pen and vial, as the date for	D 371		

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the expiration before and after opening.
-She documented the date on the attached orange sticker, provided by the pharmacy, labeled 'Date Opened', when she opened a new pen, and on the box when a new vial was opened.
-She had instructed the MAs to date the pens and vials when opened and report to her if there was no date opened on the pens or vials.
-She did not know there were insulin pens, Victoza, and vials being used to administer medications that were not dated when opened.
-She did not know insulin pens, Victoza pens, and vials were recommended by the pharmacy to be discarded after the number of days specified by the manufacturer.

Interview with the MA on 06/06/18 at 10:30am revealed:
-She documented the date the insulin pens, Victoza pen, and vials were opened on the orange sticker wrapped around the medication, applied by the pharmacy.
-She did not date any pens or vials if she had not opened them.
-She did not know when the pens and vial were opened.
-She did not remember if she informed the RCC regarding pens and vials that were not dated when opened.
-MAs had been instructed to date pens and vials when opening a new vial or pen.
-She was not sure of the expiration time frame once the medication was opened.
-She interpreted the manufacturer's expiration date, stamped on the insulin pens, Victoza pen, and vial, as the date for the expiration of the medication before and after opening.
-She did not know the pens and vials expired within a specified time frame after opening, according to pharmaceutical recommendations.

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D 371	Continued From page 8 Interview with the Pharmacist on 06/06/18 at 1:47pm revealed: -If the insulin pens and vials were not dated when opened, there was no way to identify how long the insulin had been opened. -The Pharmacist recommended to discard the insulin pen and vials that were not dated when opened and refill those medications. -The preservative added to the insulin in the pens and vials stabilized the product and prevented bacteria from forming in the pen or vial. -"The quality of the product (insulin) could not be guaranteed after the expiration date (number of days specified by the manufacturer)." Interview with the Manager on 06/06/18 at 1:55pm revealed: -She relied on the RCC to oversee medication administration and education. -She did not know that the insulin pens, Victoza, and insulin vials had an expiration date after opening. -She believed the pens and vials could be used until the medication was completed. Interview with the RCC on 06/06/18 at 2:05pm revealed: -She did not perform medication cart audits to review expiration dates of medications. -She did not review the labeling of the opened-on dates for medications. -It was the responsibility the MAs to document the opened-on dates for medications. -She had informed the MAs in the past, to label and date the medications when opened. Attempted telephone interview with the NP on 06/06/2018 at 2:58pm was unsuccessful.	D 371		