STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	09/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 completed a Annual survey on 09/04/18, 09/05/18 and 09/06/18.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 7 sampled residents (#3, #6, #7, and #2) related to insulin (Resident #3 and #6), a medication for high blood pressure (Resident #7), discontinued medications for depression, nerve pain and seizures, panic disorder, anxiety, and pain (Resident #2). The findings are: 1. Review of Resident #3's current FL2 dated 05/10/18 revealed: -Diagnoses included dementia, hypertension, diabetes, chronic obstructive pulmonary disease, and prostate cancer. -There was an order to check finger stick blood	D 358		

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sugars (FSBS) four times daily.
-There was an order for Novolog (treats high blood glucose) Sliding Scale Insulin (SSI) three times daily before meals; FSBS 0-170 give 0 units of insulin, FSBS 171-200 give 5 units of insulin, FSBS 201-250 give 10 units of insulin, and greater than 251 give 15 units of insulin.

Review of Resident #3's July 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Novolin Regular SSI three times daily before meals, for FSBS 0-170 = 0 units, 171-200 = 5 units, 201-250 = 10 units, greater than 251 = 15 units, with scheduled administration times of 7:00am, 11:30am, and 5:00pm.
-On 07/01/18 at 8:00pm, the FSBS was 319 and 18 units of insulin was documented as administered.
-On 07/03/18 at 8:00pm, the FSBS was 215 and 18 units of insulin was documented as administered.
-On 07/04/18 at 7:00am, the FSBS was 270 and 10 units of insulin was documented as administered.
-On 07/06/18 at 8:00pm, the FSBS was 196 and 18 units of insulin was documented as administered.
-On 07/08/18 at 8:00pm, the FSBS was 267 and 18 units of insulin was documented as administered.
-On 07/10/18 at 8:00pm, the FSBS was 267 and 18 units of insulin was documented as administered.
-On 07/11/18 at 8:00pm, the FSBS was 266 and 18 units of insulin was documented as administered.
-On 07/12/18 at 8:00pm, the FSBS was 267 and 18 units of insulin was documented as

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administered.
-On 07/14/18 at 5:00pm, the FSBS was 267 and 10 units of insulin was documented as administered.
-On 07/18/18 at 7:00am, the FSBS was 270 and 10 units of insulin was documented as administered.
-On 07/18/18 at 8:00pm, the FSBS was 306 and 18 units of insulin was documented as administered.
-On 07/23/18 at 5:00pm, the FSBS was 159 and 5 units of insulin was documented as administered.
-On 07/25/18 at 5:00pm, the FSBS was 188 and 0 units of insulin was documented as administered.
-On 07/25/18 at 8:00pm, the FSBS was 301 and 18 units of insulin was documented as administered.
-On 07/26/18 at 8:00pm, the FSBS was 237 and 18 units of insulin was documented as administered.
-On 07/27/18 at 8:00pm, the FSBS was 195 and 18 units of insulin was documented as administered.

Review of Resident #3's August 2018 eMAR revealed:
-There was an entry for Novolin Regular SSI three times daily before meals, for FSBS 0-170 = 0 units, 171-200 = 5 units, 201-250 = 10 units, greater than 251 = 15 units, with scheduled administration times of 7:00am, 11:30am, and 5:00pm.
-On 08/09/18 at 5:00pm, the FSBS was 186 and 0 units of insulin was documented as administered.
-On 08/15/18 at 5:00pm, the FSBS was 182 and 0 units of insulin was documented as administered.

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D 358	Continued From page 3 -On 08/19/18 at 5:00pm, the FSBS was 177 and 0 units of insulin was documented as administered. -On 08/20/18 at 5:00pm, the FSBS was 188 and 0 units of insulin was documented as administered. -On 08/21/18 at 7:00am, the FSBS was 189 and 0 units of insulin was documented as administered. -On 08/21/18 at 5:00pm, the FSBS was 178 and 0 units of insulin was documented as administered. -On 08/22/18 at 5:00pm, the FSBS was 182 and 0 units of insulin was documented as administered. -On 08/29/18 at 5:00pm, the FSBS was 189 and 0 units of insulin was documented as administered. Review of Resident #3's September 2018 eMAR revealed: -There was an entry for Novolin Regular SSI three times daily before meals, for FSBS 0-170 = 0 units, 171-200 = 5 units, 201-250 = 10 units, greater than 251 = 15 units, with scheduled administration times of 7:00am, 11:30am, and 5:00pm. -On 09/02/18 at 5:00pm, the FSBS was 199 and 0 units of insulin was documented as administered. Telephone interview on 09/04/18 at 3:38pm with a pharmacy technician at the facility's contracted pharmacy regarding Resident #3 revealed: -The pharmacy had received an order on 04/26/18 for Novolin SSI three times daily before meals, for FSBS 0-170 give 0 units of insulin, FSBS 171-200 give 5 units of insulin, FSBS 201-250 give 10 units of insulin, FSBS greater than 251 give 15 units of insulin.	D 358		

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D 358	Continued From page 4 -The pharmacy had no other SSI orders. Interview on 09/04/18 at 11:30am with a first shift medication aide (MA) revealed: -She knew how much insulin to give Resident #3 "from memory". -The SSI was written on a piece of paper in Resident #3's nightstand. Interview on 09/06/18 at 7:50am with Resident #3 revealed: -The MAs had been checking the resident's blood sugar and giving insulin. -The MAs knew how much insulin to give because he had the SSI written on a piece of paper in the nightstand. -"They (MAs) look at that." Observation on 09/06/18 at 7:51am of Resident #3's nightstand drawer revealed: -There was a 3"x 4" torn piece of notebook paper. -Written by hand in ink on the paper was Novolin 171-200=0units, 201-250=10units, greater than 250=15units. Telephone interview on 09/05/18 at 9:42am with a second shift MA revealed: -The MA worked full time on second shift. -Resident #3 had a "little book" in the nightstand with the SSI written down on it. -"I was going by that." -"I didn't know the order had changed." Telephone interview on 09/05/18 at 11:45am with the prescribing physician revealed: -The facility staff had not notified the physician of any medication errors for Resident #3. -Receiving too much insulin could cause Resident #3's blood sugar to "bottom out". -Receiving too little insulin could put Resident #3	D 358		

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at risk of a "diabetic coma".
-Resident #3's Hemoglobin A1C (blood test that measures a three month average of blood glucose) level on 08/15/18 was 7.2.
-"Luckily (Resident #3's name) is pretty well controlled."

The American Diabetes Association recommends a hemoglobin A1C target level of less than 7%. (The A1C test give you a picture of your average blood glucose [blood sugar] control for the past 2 to 3 months. The results give you a good idea of how well the residents' diabetes treatment plan is working).

Refer to the interview on 09/05/18 at 9:15am with the Special Care Coordinator (SCC).

Refer to the interview on 09/05/18 at 10:00am with the Administrator.

2. Review of Resident #6's current FL2 dated 07/02/18 revealed:
-Diagnoses included dementia, anemia, hypertension, diabetes, and acute kidney failure.
-There was an order for Novolog (treats high blood glucose) SSI three times daily before meals, FSBS 100-150 give 2 units, 151-200 give 4 units, 201-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units, do not give if resident does not eat.

Review of a clarification order dated 07/02/18 revealed the SSI parameters for FSBS 100-150 give 2 units, 151-200 give 4 units, 201-250 give 6 units, 251-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units of insulin.

Review of Resident #6's July 2018 electionic Medication Administration Record (eMAR)

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D 358	Continued From page 6 revealed: -There was an entry under Order for Novolog SSI three times daily for FSBS 100-150 give 2 units, 151-200 give 4 units, 201-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units. -There was a record entry under Special Instructions for Novolog SSI three times daily before meals for FSBS 100-150 give 2 units, 151-200 give 4 units, 201-250 give 6 units, 251-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units, do not give if resident does not eat. -On 07/06/18 at 5:00pm, the FSBS was 239 and 8 units of insulin was documented as administered. -On 07/11/18 at 11:00am, the FSBS was 218 and 8 units of insulin was documented as administered. -On 07/12/18 at 5:00pm, the FSBS was 267 and 6 units of insulin was documented as administered. -On 07/13/18 at 11:00am, the FSBS was 245 and 8 units of insulin was documented as administered. -On 07/20/18 at 5:00pm, the FSBS was 221 and 8 units of insulin was documented as administered. -On 07/21/18 at 5:00pm, the FSBS was 213 and 8 units of insulin was documented as administered. -On 07/24/18 at 5:00pm, the FSBS was 235 and 8 units of insulin was documented as administered. -On 07/26/18 at 11:00am, the FSBS was 205 and 8 units of insulin was documented as administered. -On 07/26/18 at 5:00pm, the FSBS was 237 and 8 units of insulin was documented as administered. -On 07/27/18 at 5:00pm, the FSBS was 207 and	D 358		

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D 358	Continued From page 7 8 units of insulin was documented as administered. -On 07/28/18 at 5:00pm, the FSBS was 220 and 8 units of insulin was documented as administered. -On 07/29/18 at 11:00am, the FSBS was 213 and 8 units of insulin was documented as administered. -On 07/30/18 at 11:00am, the FSBS was 235 and 8 units of insulin was documented as administered. -On 07/31/18 at 11:00am, the FSBS was 229 and 8 units of insulin was documented as administered. -On 07/31/18 at 5:00pm, the FSBS was 202 and 8 units of insulin was documented as administered. Review of Resident #6's August 2018 eMAR revealed: -There was an entry under Order for Novolog SSI three times daily for FSBS 100-150 give 2 units, 151-200 give 4 units, 201-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units. -There was record entry under Special Instructions for Novolog SSI three times daily before meals for FSBS 100-150 give 2 units, 151-200 give 4 units, 201-250 give 6 units, 251-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units, do not give if resident does not eat. -On 08/02/18 at 11:00am, the FSBS was 241 and 8 units of insulin was documented as administered. -On 08/04/18 at 5:00pm, the FSBS was 236 and 8 units of insulin was documented as administered. -On 08/08/18 at 5:00pm, the FSBS was 208 and 8 units of insulin was documented as administered.	D 358		

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-On 08/12/18 at 11:00am, the FSBS was 400 and 0 units of insulin was documented as administered.
-On 08/13/18 at 5:00pm, the FSBS was 212 and 8 units of insulin was documented as administered.
-On 08/14/18 at 5:00pm, the FSBS was 221 and 8 units of insulin was documented as administered.
-On 08/18/18 at 5:00pm, the FSBS was 212 and 8 units of insulin was documented as administered.
-On 08/19/18 at 5:00pm, the FSBS was 233 and 8 units of insulin was documented as administered.
-On 08/20/18 at 5:00pm, the FSBS was 212 and 8 units of insulin was documented as administered.
-On 08/21/18 at 11:00am, the FSBS was 246 and 8 units of insulin was documented as administered.
-On 08/23/18 at 5:00pm, the FSBS was 212 and 8 units of insulin was documented as administered.
-On 08/26/18 at 5:00pm, the FSBS was 239 and 8 units of insulin was documented as administered.

Review of Resident #6's September 2018 eMAR revealed the insulin was administered as ordered.

Review of lab results dated 03/15/18 for Resident #6 revealed the Hemoglobin A1c was 7.6.

The American Diabetes Association recommends a hemoglobin A1C target level of less than 7%. (The A1C test gives you a picture of your average blood glucose [blood sugar] control for the past 2 to 3 months. The results give you a good idea of how well the residents' diabetes treatment plan is

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D 358	Continued From page 9 working). Interview on 09/05/18 at 2:35pm with a pharmacy technician at the facility's contracted pharmacy regarding Resident #6 revealed: -The pharmacy had received an order for Novolog SSI three times daily before meals, FSBS 100-150 give 2 units, 151-200 give 4 units, 201-300 give 8 units, 301- 350 give 10 units, 351-400 give 12 units. -The pharmacy had received the order on 04/25/18. -The pharmacy had no other SSI orders or clarification orders. Interview on 09/05/18 at 1:45pm with a second shift medication aide (MA) revealed: -The MA knew to read the eMAR for the appropriate dose of insulin. -When the MA entered the FSBS on the eMAR, the eMAR would show the correct dose to give. -The MA was not aware she had given incorrect doses of insulin. Interview on 09/05/18 at 1:15pm with Resident #6 revealed: -The resident did have her FSBS checked and insulin was given. -"They just know how much insulin to give." Telephone interview on 09/06/18 at 9:05am with the prescribing physician's medical assistant revealed: -Not giving the ordered doses of insulin to Resident #6 was "potentially dangerous" to the resident. -The physician had not been notified of the incorrect doses of insulin given. -"Giving the wrong dose could cause her sugar to bottom out or a diabetic coma."	D 358		

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D 358	Continued From page 10 Refer to the interview on 09/05/18 at 9:15am with the SCC. Refer to the interview on 09/05/18 at 10:00am with the Administrator. 3. Observation on 09/05/18 at 9:00am during the medication pass revealed the Medication Aide (MA) crushed metoprolol (treats high blood pressure) 25mg Extended Release (ER) one tablet, placed it it applesauce and administered it to Resident #7. Review of Resident #7's current FL2 dated 05/04/18 revealed: -Diagnoses included dementia, gastro esophageal reflux, renal insufficiency, and liver cyst. -There was an order for metoprolol succinate ER 25mg take 1 tablet every morning. Observation of Resident #7's medication on hand on 09/05/18 at 9:01am revealed: -Do not Chew or Crush before swallowing was printed on the label of metoprolol succinate ER 25mg. -30 tablets were dispensed on 07/30/18 with 5 tablets remaining in the bubble pack. Interview on 09/05/18 at 9:00am with the MA revealed: -The MA always crushed all of Resident #7's medications. -The "managers" had told the MA to crush all Resident #7's medications. -"I was not told not to crush extended release medications." Telephone interview on 09/05/18 at 9:05am with a	D 358		

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pharmacist from the dispensing pharmacy revealed:
-The metoprolol 25mg ER tablet should not be crushed.
-The outer coating allows for the medication to be released over 24 hours.
-Crushing the medication would allow the medication to be released into the body all at once.
-Acids in the stomach could deactivate the medication.

Review of a physician's order dated 01/26/18 revealed may crush all medications.

Telephone interview on 09/05/18 at 9:36am with the Nurse Practitioner (NP) revealed:
-The NP had signed a may crush medications order on 01/26/18.
-"That's an error on my part on that crush order (for the metoprolol succinate ER 25mg).

Refer to the interview on 09/05/18 at 9:15am with the SCC.

Refer to the interview on 09/05/18 at 10:00am with the Administrator.

_____

Interview on 09/05/18 at 9:15am with the SCC revealed:
-The SCC had been hired into the position "about 3 weeks ago".
-The SCC was responsible for reviewing new orders and faxing them to the pharmacy.
-She would compare entries on the eMAR with the physician orders.
-The medication aides would be receiving more training on medications.

Interview on 09/05/18 at 10:00am with the

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D 358	Continued From page 12 Administrator revealed: -The Administrator was "new here". -The SCC was responsible for reviewing new orders. -He expected the medications to be given as ordered. -The MAs would be receiving additional training on medications. The facility failed to administer medications as ordered, including incorrect doses of insulin to Resident #3 and #6; a crushed blood pressure medication to Resident #7. This failure increased the potential of hyper/hypoglycemia for Resident #3 and #6 and elevated blood pressure in Resident #7. The facility's failure to administer medications as ordered was detrimental to the health and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/05/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 21, 2018.	D 358		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to	D 468		

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KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 468	Continued From page 13 be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure staff assigned to work in a special care unit (SCU) had completed 6 hours of orientation during the first week of employment and 20 hours of training within six months of employment for 2 of 3 sampled staff (Staff A and B). The findings are: 1. Review of Staff A's personnel file revealed: -Staff A was hired as medication aide (MA) on 03/22/17. -There was no documentation of SCU training during the first week of employment.	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	09/06/2018

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D 468	Continued From page 14 -There was no documentation of SCU training within the first six months of employment. Interview on 09/05/18 at 1:05pm with Staff A revealed: -Staff A was hired as a MA in March 2017 and worked full time hours. -"I don't think I had six hours of training in the first week." -Staff A remembered completing some dementia training after the first week of employment. -Staff A was not aware of how many hours of training she had completed. Refer to the interview on 09/05/18 at 2:50pm with the Business Office Manager. Refer to the interview on 09/05/18 at 1:22pm with the Administrator. Refer to the interview on 09/05/18 at 1:30pm with the Regional Director of Operations. 2. Review of Staff B's personnel file revealed: -Staff B was hired as a medication aide (MA) on 01/01/18. -There was no documentation of SCU training during the first week of employment. -There was no documentation of SCU training within the first six months of employment. Interview on 09/05/18 at 1:45pm with Staff B revealed: -Staff B knew she had dementia training. -"It's done on a computer." -Staff B was not aware how many hours of dementia training she had completed. -"I don't keep any documents."	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 468	Continued From page 15 Refer to the interview on 09/05/18 at 2:50pm with the Business Office Manager. Refer to the interview on 09/05/18 at 1:22pm with the Administrator. Refer to the interview on 09/05/18 at 1:30pm with the Regional Director of Operations. Interview on 09/05/18 at 2:50pm with the Business Office Manager (BOM) revealed: -She was hired August 8th 2018. -Staff completed some dementia training on the computer before they started work in the facility. Interview on 09/05/18 at 1:22pm with the Administrator revealed: -The Administrator was not aware staff needed the 6 hour and 20 hour dementia training. -Training has been an issue here. -"We are bringing people in to train the staff." Interview on 09/05/18 at 1:30pm with the Regional Director of Operations revealed all staff would be scheduled to complete the training.	D 468		
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:	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 16 Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 7 sampled residents (#3, #6 and #7.) related to insulin (Resident #3 and #6), a medication for high blood pressure (Resident #7). [Refer to Tag 0358, 10A NCAC 13G .1004(a) Type B Violation].	D912		