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
	HAL032001	A. BUILDING: _____ B. WING _____	R-C 10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENO POINTE ASSISTED LIVING	5600 N ROXBORO ROAD DURHAM, NC 27712

(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 and complaint investigation on October 1 - 4, 2019.	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, record reviews, and interviews, the facility failed to administer medications to 1 of 7 sampled residents (#5) as ordered by the physician including a diabetic medication administered at bedtime. The findings are: Review of Resident #5's current FL-2 dated 08/14/19 revealed: -Diagnoses included: rheumatoid arthritis, type 2	D 358	We had a second meeting with Pharmacy Manager on 10-14-19 about increasing number of input errors by their personnel. We requested a third Pharmacist sign off on each order input to ensure on-going accuracy, as they key orders onto our MARs. Med Techs in-serviced on 10-14-19 by Pharmacist on Med Administration. New orders/changes will be notated by a flag when input by Pharmacy; RCC or designee will review each for accuracy. Completed: 10-14-19	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11-08-19

Reviewed and accepted on 11/18/19- SS

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D 358	Continued From page 1 diabetes mellitus without complications, chronic kidney disease stage 3, difficulty walking, and hypertension. -There was an order for Novolog insulin (used to treat diabetes mellitus) per sliding scale: FSBS 150 - 200 give 1 unit, 201 - 250 give 2 units, 251 - 300 give 3 units, and 300 - 350 give 4 units and notify the physician. Review of Resident #5's subsequent physician orders revealed there was a medication order dated 09/24/19 for Novolog insulin documents as, please increase sliding scale insulin as follows: "if pre- meal glucose is" 150 - 200 give 2 units Novolog, 201 - 250 give 3 units Novolog, 251 - 300 give 4 units Novolog, and 301 - 350 give 5 units Novolog. Review of Resident #5's July 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novolog injection use per sliding scale for blood glucose 150 - 200 = 1 unit, 200 - 250 = 2 units, 250 - 300 = 3 units, 300 - 350 = 4 units and notify physician, scheduled for 7:30 am, 11:30 am, and 5:30 pm. -There was documentation of administration with staff initials, blood glucose reading, injection site location and amount of insulin given from 07/01/19 to 07/31/19 at 7:30 am, and 11:30 am. -There was documentation of administration with staff initials, blood glucose reading, injection site location and amount of insulin given from 07/01/19 to 07/26/19 at 5:30 pm and from 07/28/19 to 07/31/19 at 5:30 pm. -There was no documentation of administration on 07/27/19 at 5:30 pm. -There was documentation of blood glucose readings that ranged from 96 - 352.	D 358		

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D 358	Continued From page 2 Review of Resident #5's August 2019 eMAR revealed: -There was an entry for Novolog injection use per sliding scale for blood glucose 150 - 200 = 1 unit, 200 - 250 = 2 units, 250 - 300 = 3 units, 300 - 350 = 4 units and notify physician, scheduled for 7:30 am, 11:30 am, and 5:30 pm. -There was documentation of administration with staff initials, blood glucose reading, injection site location and amount of insulin given from 08/01/19 to 08/31/19 at 7:30 am, and 11:30 am. -There was documentation of administration with staff initials, blood glucose reading, injection site location and amount of insulin given from 08/01/19 to 08/30/19 at 5:30 pm. -There was no documentation of administration on 08/31/19 at 5:30 pm. -There was documentation of blood glucose readings that ranged from 98 - 388. Review of Resident #5's September 2019 eMAR revealed: -There was an entry for Novolog injection use per sliding scale for blood glucose 150 - 200 = 1 unit, 200 - 250 = 2 units, 250 - 300 = 3 units, 300 - 350 = 4 units and notify physician, scheduled for 7:30 am, 11:30 am, and 5:30 pm. -There was documentation of administration with staff initials, blood glucose reading, injection site location and amount of insulin given from 09/01/19 to 09/23/19 at 7:30 am, 11:30 am, and 5:30 pm. -There was documentation of administration with staff initials, blood glucose reading, injection site location and amount of insulin given on 09/24/19 at 7:30 am. -There was an entry for Novolog injection inject subcutaneously before meals and at bedtime per sliding scale as follows: 150 - 200 = 2 units, 201 - 250 = 3 units, 251 - 300 = 4 units, 301 - 350 = 5	D 358		

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units, scheduled for 7:30 am, 8:00 am, 11:30 am, 12:00 pm, 5:00 pm, 5:30 pm, and 8:00 pm.
-There was no documentation of administration on 09/24/19 at 7:30 am, 8:00 am, 11:30 am and 5:30 pm, on 09/25/19 at 7:30 am, 11:30 am and 5:30 pm.
-There was no documentation of administration on 09/26/19 at 7:30 am, 12:00 pm, 5:00 pm and from 09/27/19 to 09/30/19 at 8:00 am, 12:00 pm and 5:00 pm.
-There was documentation of administration on 09/24/19 at 12:00 pm, 5:00 pm, and 8:00 pm, on 09/25/19 at 8:00 am, 12:00 pm, 5:00 pm, and 8:00 pm, and on 09/26/19 at 8:00 am, 11:30 am, 5:30 pm, and 8:00 pm.
-There was documentation of administration on 09/27/19 to 09/30/19 at 7:30 am, 11:30 am, 5:30 pm, and 8:00 pm.
-There was documentation of blood glucose readings that ranged from 100 - 502.

Review of Resident #5's October 2019 eMAR revealed:
-There was an entry for Novolog injection inject subcutaneously before meals and at bedtime per sliding scale as follows: 150 - 200 = 2 units, 201 - 250 = 3 units, 251 - 300 = 4 units, 301 - 350 = 5 units, scheduled for 7:30 am, 11:30 am, 5:30 pm, and 8:00 pm.
-There was documentation of administration on 10/01/19 at 7:30 am, 11:30 am, 5:30 pm, and 8:00 pm.
-There was documentation of administration on 10/02/19 at 7:30 am.
-There was documentation of blood glucose readings that ranged from 91 - 350.

Based on record reviews and interviews, Resident #5 had Novolog insulin administered 7 times at bedtime from 09/25/19 t0 10/01/19.

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Review of Resident #5's Novolog insulin label revealed:
-There was a dispense date of 09/24/19.
-There were administration instructions as follows: Novolog injection inject subcutaneously before meals and at bedtime per sliding scale as follows: 150 - 200 = 2 units, 201 - 250 = 3 units, 251 - 300 = 4 units, 301 - 350 = 5 units.

Observation of Resident #5's medication on 10/03/19 at 9:52 am revealed there was one vial of Novolog available for administration.

Interview with Resident #5 on 10/01/19 at 10:17 am revealed she had her blood glucose checked by staff and she had insulin administered by staff.

Attempted telephone interviews with Resident #5's physician on 10/02/19 at 12:13 pm and 10/04/19 at 12:58 pm were unsuccessful.

Telephone interview with a representative at the facility's contracted pharmacy on 10/02/19 at 11:55 am revealed:
-There was an order from Resident #5's physician dated 09/24/19 for Novolog sliding scale insulin if pre- meal glucose is 150 - 200 = 2 units, 201 - 250 = 3 units, 251 - 300 = 4 units, 301 - 350 = 5 units.
-The order was placed into the computer system as before meals and at bedtime but that was not the physician's order.
-She thought the person who entered the written physician's order into the computer system made an error and she planned to contact the physician and the facility to make them aware.
-The pharmacy had placed the times on the MAR for an additional 8:00 pm administration of sliding scale insulin.

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D 358	Continued From page 5 -This was an oversight by the pharmacy and corrective actions would be taken. Interview with a first shift Medication Aide (MA) on 10/04/19 at 9:15 am revealed: -Family members brought new physician orders in when they transported the residents to outside physician appointments. -Any new physician orders were given to the Resident Care Coordinator (RCC). -The RCC placed orders into the eMAR system she thought. -She thought the RCC and the night shift MA checked to see if the physician orders matched the eMAR entry. -The RCC had to approve the eMAR entry before the MAs could administer the medication. Interview with another first shift Medication Aide (MA) on 10/04/19 at 10:17 am revealed the RCC had to verify a medication on the eMAR system before the MAs could administer the medication. Interview with the second shift Supervisor/MA on 10/04/19 at 11:15 am revealed all new orders were processed by the RCC which included faxing the new order to pharmacy and sometimes placing the order into the eMAR computer system. Interview with the first shift Supervisor/MA on 10/04/19 at 12:42 pm revealed: -She knew Resident #5 had an order for sliding scale insulin and it was changed in September 2019. -The RCC faxed over any new medication orders to pharmacy, the pharmacy entered the new medication order into the eMAR system, then the RCC had access to enter the eMAR system to check the eMAR entry against the physician's	D 358		

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order to verify the accuracy of the eMAR entry.
-She was aware of the process because she was responsible for completing this duty for one week when the RCC was on leave.
-When she processed the orders for the one week, she notified pharmacy when there was a discrepancy between the eMAR entry and the physician's order.
-Also, when a medication order was changed or new, the word new appeared on the eMAR screen for that medication entry, but she did not know how long the word remained in the system.
-She did not know Resident #5 was receiving a bedtime dose of insulin.
-She did not know of any low blood glucose readings for Resident #5.
-She did not enter the eMAR system to check the medication orders against the eMAR entry on a routine basis, just when the RCC was on leave.
-The RCC was responsible for ensuring the medication orders were accurate in the eMAR system.

Interview with the RCC on 10/04/19 at 2:19 pm revealed:
-The MAs administered medications according to the MAR entry.
-She did the orders herself by faxing the new medication orders to the pharmacy, the pharmacy entered the order into the eMAR system, and she approved the medication order before it was administered.
-She received new orders from the transportation person or family members upon the residents return to the facility.
-The MAs did not put any orders into the eMAR system.
-After hours and on the weekends, she had access to the eMAR system because she had a computer at home that accessed the system.

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D 358	Continued From page 7 -Also, she received photos of the new orders and she placed the new medication order into the eMAR system after hours or on the weekends. -When she approved or verified the medication entry, she looked at the dose like how many milligrams, the instructions for administration and the times of administration, the medication and ensured that it matched the physician order. -She had a problem with Resident #5's 09/24/19 sliding scale insulin order because there were additional times appearing on the screen, she accessed to verify the order. -She called the pharmacy on 09/24/19 and spoke with a representative who told her the times were corrected so she verified the order. -She thought the times were correct and did not know the instructions included bedtime and an 8:00 pm administration time, because she did not scroll down on the screen, she used to verify entries in the eMAR system. -She thought she had taken care of the error in the eMAR system by notifying pharmacy before approving the entry, but she did not scroll down to see all of the administration times. -She was responsible for ensuring the entries in the eMAR system were accurate so that the MAs administered medications correctly. -She did weekly reviews, but she did not see Resident #5's insulin order error on the eMAR entry. Interview with the Administrator on 10/04/19 at 3:25 pm revealed: -The RCC received and processed all medication orders. -The pharmacy and the RCC both found errors with medication entries and the RCC notified the pharmacy when she found discrepancies on the eMAR system. -The pharmacy entered the medication order	D 358		

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D 358	Continued From page 8 initially and the RCC verified the accuracy of the eMAR entry before the MAs administered medications. -She had a meeting with the pharmacy manager about the pharmacy discrepancies and she thought it was beneficial to have another person verifying the medication order entry before the MAs administered the medications.	D 358		