PRINTED: 12/10/2021
FORM APPROVED

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
	HAL096029	A. BUILDING: _____ B. WING _____	R 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON'S RETIREMENT CENTER	4258 HWY 13 NORTH GOLDSBORO, NC 27534

(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 11/30/21-12/01/21.	{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 as ordered and in accordance with the facility's policies for 2 of 4 residents (#4 and #5) observed during the medication passes including errors with insulin (#4, #5). The findings are: The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 8:00am and 12:00pm medication passes on 11/30/21. 1. Review of Resident #4's current FL-2 dated 06/10/21 revealed diagnoses included diabetes. Review of Resident #4's physician's orders dated 09/09/21 revealed there was an order for Lantus 26 units to be administered every morning (Lantus is a long-acting insulin used to treat diabetes).	{D 358}	All medication aid staff took diabetes & medication administration update classes. Administrator reviewed ~~policies~~ med administration policies with med. techs and importance of this. Insulin administration was reviewed also. Both the diabetes and med update classes provided by our contracted pharmacy. 12/22/21	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kenneth S Ing

TITLE: Administrative

(X6) DATE: 1-27-22

STATE FORM 6899 OZ1D12 If continuation sheet

Received via email 1/28/22
Reviewed and acknowledged

Susan Skinner, MSW 1/28/22

	HAL096029	A. BUILDING: _____ B. WING _____	R 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON'S RETIREMENT CENTER	4258 HWY 13 NORTH GOLDSBORO, NC 27534

(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 358}	Continued From page 1 Observation of the 8:00am medication pass on 11/30/21 revealed: -The medication aide (MA) retrieved a new Lantus pen for Resident #4 from the medication refrigerator. -The MA dialed up 26 units on the Lantus pen with the cap on the pen, then removed the cap, and attached the needle. -The MA did not prime the insulin pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing through the needle and that the resident received the full dose of insulin. -The MA administered 26 units of Lantus to Resident #4 in her left lower abdomen and held the pen in for the injection for 2 seconds at 8:46am. Review of the prescribing information from the Lantus manufacturer revealed: -After the needle was attached, a safety test should have been performed. -The safety test is performed by dialing a test dose of 2 units. -The MA shall press the injection button and check to see that insulin comes out of the needle. -The MA shall hold the injection for 10 seconds to ensure that the full dose is administered. Review of Resident #4's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus 26 units inject subcutaneously every morning, scheduled for administration at 8:00am, with instructions to prime the insulin pen with 2 units prior to each use. -Lantus 26 units was documented as administered on 11/30/21 at 8:00am.	{D 358}	Administrator will monitor on a monthly basis by doing routines med pass observations by med-techs. Administrator will also review MARs on monthly basis.	12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096029	A. BUILDING: _____ B. WING _____	R 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON'S RETIREMENT CENTER	4258 HWY 13 NORTH GOLDSBORO, NC 27534

(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 358}	Continued From page 2 -Resident #4's blood sugar ranged from 90-566. Interview with Resident #4 on 11/30/21 at 8:59am revealed: -The MAs were responsible for administering her insulin and she was not sure about the process of preparing the insulin pen for administration. -She did not recall how long they hold the injection in her abdomen. Interview with the MA on 11/30/21 at 3:00pm revealed: -She was trained to prime Resident #4's Lantus pen with a 2 unit air shot. -She was nervous during the medication pass and forgot to prime Resident #4's Lantus pen with the air shot prior to administering her insulin. -She was trained to hold Resident #4's Lantus pen in the injection site while administering for 10 seconds. -She was nervous during the medication pass and forgot to hold Resident #4's Lantus pen at the injection site for at 10 seconds while administering her insulin. Interview with a pharmacist at the facility's contracted pharmacy on 12/01/21 at 10:55am revealed: -Lantus should be administered according to the manufacturer's recommendations. -The Lantus pens should be primed with 2 units of an air shot to ensure that the resident receives the complete dose ordered. -The air shot would not likely affect Resident #4's blood sugar unless it was a new pen that the MA was using to administer the Lantus. -The Lantus pens should be held at the injection site for 10 seconds to ensure that the resident receives the complete dose ordered. -The MA not holding the insulin pen for 10	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096029	A. BUILDING: _____ B. WING _____	R 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON'S RETIREMENT CENTER	4258 HWY 13 NORTH GOLDSBORO, NC 27534

(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 358}	Continued From page 3 seconds would not likely affect Resident #4's blood sugar unless there was visible insulin leaking from the injection site. Interview with the Administrator on 11/30/21 at 3:15pm revealed she expected Resident #4 to receive her Lantus insulin according to manufacturer's recommendation including priming the pen with the air shot prior to administration and holding the insulin pen at the injection site for 10 seconds during administration. . Attempted telephone interview with Resident #4's primary care provider (PCP) on 12/01/21 at 1:15pm was unsuccessful. 2. Review of Resident #5's current FL-2 dated 12/03/20 revealed diagnoses included diabetes. Review of Resident #5's physician's orders dated 10/08/21 revealed there was an order for Novolog sliding scale insulin to be administered before meals and at bedtime for blood sugar 201-250= 3 units, 251-300=6 units, 301-350= 8 units, 351-400= 10 units, over 400 notify the on call physician (Novolog is a short-acting insulin used to treat diabetes that starts to lower blood sugar approximately 30 minutes after administration). Observation of the 12:00pm medication pass on 11/30/21 revealed: -Resident #5's blood sugar at 11:02am was 360. -The medication aide (MA) dialed up 10 units on Resident #5's Novolog pen with the cap on the pen, then removed the cap, and attached the needle. -The MA did not prime the Novolog pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096029	A. BUILDING: _____ B. WING _____	R 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON'S RETIREMENT CENTER	4258 HWY 13 NORTH GOLDSBORO, NC 27534

(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 358}	Continued From page 4 through the needle and that the resident received the full dose of insulin. -The MA administered 10 units of Novolog to Resident #5 in her right thigh and immediately removed the pen at 11:06am. -There was visible clear liquid pooled on Resident #5's right thigh after the Novolog pen was injected. Review of the prescribing information from the Novolog manufacturer revealed: -After the needle was attached, a safety test should have been performed. -The safety test is performed by dialing a test dose of 2 units. -The MA shall press the injection button and check to see that insulin comes out of the needle. -The MA shall hold the injection for 10 seconds to ensure that the full dose is administered. Interview with the MA on 11/30/21 at 11:30am revealed lunch was served between 12:00pm and 12:30pm. Observation of the women's dinning room on 11/30/21 at 12:19pm revealed Resident #5 was served lunch including chicken and pastry, carrots, pears and a muffin. Review of Resident #5's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog sliding scale insulin to be administered before meals and at bedtime for blood sugar 201-250= 3 units, 251-300=6 units, 301-350= 8 units, 351-400= 10 units, scheduled for administration at 7:30am, 11:30am, 4:30pm, and 8:00pm with instructions to prime the insulin pen with 2 units prior to each use.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096029	A. BUILDING: _____ B. WING _____	R 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON'S RETIREMENT CENTER	4258 HWY 13 NORTH GOLDSBORO, NC 27534

(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 358}	Continued From page 5 -Novolog 10 units was documented as administered on 11/30/21 at 11:30am. -Resident #5's blood sugars ranged from 115 to 395. Interview with Resident #5 on 11/30/21 at 2:10pm revealed: -The MAs were responsible for preparing and administering her insulin. -She did not remember what time she ate in relation to when she received her insulin. Interview with the MA on 11/30/21 at 3:00pm revealed: -She was trained to prime Resident #5's Novolog pen with a 2 unit air shot. -She was nervous during the medication pass and forgot to prime Resident #5's Novolog pen with the air shot prior to administering her insulin. -She was trained to hold Resident #5's Novolog pen in the injection site while administering for 10 seconds. -She was nervous during the medication pass and forgot to hold Resident #5's Novolog pen at the injection site for 10 seconds while administering her insulin. Interview with a pharmacist at the facility's contracted pharmacy on 12/01/21 at 10:55am revealed: -Novolog should be administered according to the manufacturer's recommendations. -The Novolog pens should be primed with 2 units of an air shot to ensure that the resident receives the complete dose ordered. -The air shot would not likely affect Resident #5's blood sugar unless it was a new pen that the MA was using to administer the Novolog. -The Novolog pens should be held at the injection site for 10 seconds to ensure that the resident	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096029	A. BUILDING: _____ B. WING _____	R 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON'S RETIREMENT CENTER	4258 HWY 13 NORTH GOLDSBORO, NC 27534

(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 358}	Continued From page 6 receives the complete dose ordered. -The MA not holding the insulin pen for 10 seconds would not likely affect Resident #5's blood sugar unless there was visible insulin leaking from the injection site. -Novolog should not be administered more than 30 minutes of eating because it is a fast-acting insulin and can cause blood sugars to drop quickly. Interview with the Administrator on 11/30/21 at 3:15pm revealed: -She expected Resident #5 to receive her Novolog insulin according to manufacturer's recommendation including priming the pen with the air shot prior to administration and holding the insulin pen at the injection site for 10 seconds during administration. -She expected Resident #5 to receive her Novolog no more than 30 minutes prior to eating a meal. Attempted telephone interview with Resident #5's primary care provider (PCP) on 12/01/21 at 1:15pm was unsuccessful.	{D 358}		