STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345534	A. BUILDING: _____ B. WING _____	8/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

(i) Medical records.
(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and facility staff interviews, the facility failed to accurately document insulin administration for 1 of 5 residents (Resident #115).

Findings included:
A review of Resident #115 ' s care plan dated 7/28/17 revealed he had goals and interventions for diabetes mellitus, diabetic ulcers of the feet, and nutrition and hydration.

The 14-day Minimum Data Set dated 8/10/17 revealed the resident had an intact cognition. The resident required extensive assistance of one staff member for ADLs except meals were set up.

A review of Resident #115 ' s physician ' s order dated 7/27/17 for Novolog 100 units/milliliter vial insulin administered per sliding scale blood glucose level before meals and at bedtime revealed the following:

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Blood glucose 0 - 129 administer no insulin
Blood glucose 130 - 162 administer 3 units of insulin
Blood glucose 163 - 204 administer 6 units of insulin
Blood glucose 205 - 256 administer 9 units of insulin
Blood glucose 257 - 309 administer 12 units of insulin
Blood glucose 310 - 350 administer 15 units of insulin
Blood glucose 351 and up administer 18 units of insulin and call the physician

A review of the August 2017 medication administration record (MAR) revealed that the record indicated the blood glucose reading and that no insulin was administered on the following days:

8/5/17 4:30 AM BLOOD GLUCOSE 132 NO INSULIN ADMINISTERED
8/7/17 11:30 AM BLOOD GLUCOSE 166 NO INSULIN ADMINISTERED
4:30 AM BLOOD GLUCOSE 148 NO INSULIN ADMINISTERED
8/10/17 4:30 PM BLOOD GLUCOSE 141 NO INSULIN ADMINISTERED
8/11/17 11:30 AM BLOOD GLUCOSE 141 NO INSULIN ADMINISTERED

On 8/15/17 at 1:20 pm an interview was conducted with Nurse #7. Nurse #7 stated that she was the nurse for Resident #115 and had administered sliding scale insulin dose per blood glucose, but that the administration was not documented. Nurse #7 stated that the medication administration electronic medical record (EMR) was blocking the prompt to administer insulin when the blood glucose was 150 or less. Nurse #7 stated that she used an alternative method and documented in another screen, but not on the MAR. Nurse #7 stated that she had not informed the Director of Nursing (DON) or anyone else of the resident ' s EMR sliding scale insulin documentation problem. Nurse #7 completed alternate documentation and had not documented on the MAR. The problem was with the documentation.

On 8/15/17 at 1:30 pm an interview was conducted with Nurse #4. Nurse #4 stated that there was a problem with the EMR MAR recording the insulin by the blood glucose level. The facility-wide EMR insulin sliding scale began at blood glucose of 150. Resident #115 ' s insulin sliding scale began at blood glucose of 130. The EMR provided a pop-up window to document the insulin dose given according to the blood glucose level. The EMR would erroneously notify the nurse at that point in the medication administration no insulin was needed. However, the correct sliding scale was visible in the resident ' s EMR MAR.

On 8/16/17 at 1:00 pm an interview was conducted with the DON. The DON stated that she reviewed Resident #115 ' s EMR MAR and agreed that the insulin had not been given per physician's order for sliding scale insulin amount by blood glucose result. The DON stated that she verified with Nurse #7 that there was a problem with the resident ' s documentation of insulin in the EMR MAR. The DON verified that Nurse #7 had not notified anyone of the resident ' s EMR MAR insulin documentation workaround. The DON could not find any other documentation of the resident ' s insulin administration other than the MAR. The DON's expectation was for the staff to accurately document medication administration in the resident ' s MAR.

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On 8/16/17 a review of documentation from the DON for nurse education, medication administration policy, and three statements from Nurse #7, 8 & 9. Nursing education provided on 8/16/17 by the DON was for nursing staff to document all resident ' s medication administration in the MAR and if unable to document in the MAR to document in the nurses ' notes. The medication policy directed staff to document all medication administration in the resident ' s MAR. Three statements from nursing staff documented that they gave insulin to Resident #115 on six occasions that were documented as not given in the MAR. The dates were as follows: 8/5/17 at 4:40 pm 3 units of insulin were given for a blood glucose of 132; 8/7/17 at 11:30 am 3 units of insulin were given for a blood glucose of 166 (physician ' s order required 6 units); 8/7/17 at 4:30 pm 3 units of insulin were given for a blood glucose of 148; 8/10/17 at 4:30 pm 3 units of insulin were given for a blood glucose of 141; 8/11/17 at 11:30 am 3 units of insulin were given for a blood glucose of 141; and 8/11/17 at 4:30 pm 3 units of insulin were given for a blood glucose of 150.

On 8/17/17 at 11:55 am an interview was conducted with Resident #115 ' s physician. The physician stated that the insulin medication omissions were short term and would most likely not cause any microvascular harm. The physician stated that the highest blood glucose was 284 and not likely to cause diabetic ketoacidosis. The missed insulin doses were not ideal considering the resident had multiple diabetic ulcers to his toes that were not healing. The physician stated that he was most worried about an infection due to high blood glucose. The physician was also concerned about the resident ' s incorrect medication documentation and the ability to evaluate whether the insulin was at the correct dose to prevent hyper or hypoglycemia. The physician stated that he expected the facility staff to follow his orders as written and document accurately.