STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078095	A. BUILDING: _____ B. WING _____	03/24/2016

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(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 Robeson County Department of Social Services conducted an annual survey on March 22 - 24, 2016.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interview, the facility failed to assure referral of an elevated heart rate and follow up of finger stick blood sugar results according to parameters provided by the licensed practitioner to meet the routine and acute health care needs for 1 of 3 residents (Resident #3) sampled. The findings are: Review of Resident #3's current FL-2 dated 02/02/2016 revealed diagnoses included hypertension, hyperlipidemia, morbid obesity, mild mental retardation, chronic paranoid schizophrenia, and diabetes mellitus type II. a. Review of physician orders for Resident #3 dated 02/02/2016 revealed a physicians order for weekly pulse. Review of February 2016 electronic Medication Administration Records (eMARs) revealed:	D 273		

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-There was no documentation of weekly pulse.
-There was no entry to obtain a weekly pulse.

Review of March 2016 eMARs revealed weekly pulse rates included the following:
-On 03/09/2016 at 2:00pm, pulse rate of 151.
-On 03/16/2016 at 2:00pm, pulse rate of 142.

Review of care notes revealed no documentation of contact with Resident #3's Primary Care Provider (PCP) regarding the above heart rates.

(According to the National Institute of Health, 60 - 100 beats per minute is considered a normal heart rate.)

Interview with the Medication Aide (MA) on 03/23/2016 at 1:45pm revealed:
-The MA had never checked Resident #3's pulse rate.
-The MA had never had to call the physician or PCP about Resident #3.
-The MA usually worked on the 11pm - 7am shift.

Interview with the Resident Care Coordinator (RCC) on 03/23/2016 at 3:15pm revealed:
-The RCC did not know if Resident #3's pulse rate of 151 on 03/09/2016 had been referred to the PCP.
-The RCC did not know if Resident #3's pulse rate of 142 on 03/16/2016 had been referred to the PCP.
-The RCC did not know if the facility had a policy and procedure for guidance to staff on when to contact the physician regarding vital signs obtained by staff.

Interview with the Primary Care Provider (PCP) on 03/23/2016 at 3:25pm revealed:
-The PCP was aware of the 151 pulse rate for

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Resident #3.
-The PCP had rechecked Resident #3's pulse rate when it was recorded as 151 and Resident #3's pulse rate was much lower.
-The PCP did not remember if the pulse rate of 142 for Resident #3 had been bought to her attention.
-The PCP stated she probably would not have done anything different with regards to the pulse rates.
-The PCP had not provided to the facility any parameters for pulse rates on when to notify the PCP.

Refer to interview with the Executive Director and Regional Director Corporate Operations Specialist on 03/23/2016 at 3:43pm.

b. Review of physician orders for Resident #3 revealed an order dated 03/03/2016 which included to discontinue all previous blood glucose checks; blood glucose check before meals and "q" [every] 06:30am, q 11:30am, q 4:30pm; Humalog sliding scale 3 times daily injection for above sugars to be given right after meals.
0-150: no insulin, 151-200: 4 units, 201-250: 6 units, 251-300: 8 units, 301-350: 10 units, 351-400: 12 units, 401-450: 15 units, 451 or more: 15 units and call the doctor.

Review of the eMARs for March 2016 for Resident #3 revealed:
-On 03/03/2016 at 4:00pm, Resident #3's finger stick blood sugar (fsbs) was documented as 520.
-On 03/03/2016 at 8:00pm, Resident #3's fsbs was documented as 487.
-On 03/04/2016 at 12:30pm, Resident #3's fsbs was documented as 495.
-On 03/06/2016 at 4:00pm, Resident #3's fsbs was documented as 478.

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Review of Resident #3's Care Notes revealed:
-The staff documented contact with the physician on 03/03/2016 at "12:15 1st shift" when Resident #3's fsbs was "4 [there were blank spaces behind the number 4]" and the doctor stated there were new orders coming in and to only call if it's over 500.
-The staff documented calling with the physician on 03/03/2016 at "2:15 1st shift" when Resident #3's fsbs was "5 [there were blank spaces behind the number 5]" but no answer and a voicemail was left.

Interview with the Medication Aide (MA) on 03/23/2016 at 1:45pm revealed:
-The MA did not usually work on the 7am - 3pm shift.
-The MA had only been working at the facility since the end of February 2016.
-The MA had never called the physician about Resident #3's finger stick blood sugar (fsbs) results.

Interview with the RCC on 03/23/2016 at 2:25pm revealed:
-The MA was supposed to call the Provider when the fsbs readings were outside the prescribed parameters.
-The MA would document in the resident care notes or on a physician order form if the physician notification occurred for fsbs results outside the prescribed parameters for notification.

Interview with the Primary Care Provider (PCP) on 03/23/2016 at 3:25pm revealed:
-The PCP had been getting some phone calls when Resident #3's fsbs was outside the PCP prescribed parameters for notification.
-The PCP was not sure of the exact dates and

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D 273	Continued From page 4 times she had been notified. Refer to interview with the Executive Director and Regional Director Corporate Operations Specialist on 03/23/2016 at 3:43pm. _____ Interview with the Executive Director and Regional Director Corporate Operations Specialist on 03/23/2016 at 3:43pm revealed: -Parameters for notifications to the physician were individualized for each resident and should be established by the physician or PCP. -Notifications of elevated blood sugars, heart rates, blood pressures went directly to the physician's office. -Notifications from staff to the physician or PCP would be documented in the resident care notes. _____ Review of the Plan of Protection submitted by the facility on 03/23/2016 revealed: -The Administrator and Resident Care Coordinator (RCC) will assure the physician or his designee is informed of changes in condition or parameters for blood pressures, blood sugars, or vital signs and follow up on orders and document in care notes, weight book, and Coumadin book. -A new tracking order form will be implemented immediately and monitored by the RCC and Administrator to assure accurate follow-up and delivery of order and medications. -An immediate chart audit will be done 03/23/2016. -Ongoing oversight of Administrator to assure timely follow-up and compliance. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 8, 2016.	D 273		

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D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interview, the facility failed to assure physician's orders for monitoring of pulse rates (Resident #3), blood pressures (Residents #2, #3), weights (Resident #2), finger stick blood sugars (Resident #3), and food intake (Resident #1) , were implemented as ordered for 3 of 3 residents (Residents #1, #2, and #3) sampled. The findings are: 1. Review of Resident #3's current FL-2 dated 02/02/2016 revealed diagnoses included hypertension, hyperlipidemia, morbid obesity, mild mental retardation, chronic paranoid schizophrenia, and diabetes mellitus type II. Review of the Resident Register completed for Resident #3 revealed an admission date of 02/09/2016. a. Review of physician orders for Resident #3 revealed:	D 276		

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-There was a physician's order dated 02/02/2016 for weekly blood pressures and pulse.
-There was a physician's order dated 02/16/2016 for daily blood pressure for 14 days and record on medication administration record (MAR).
-There was a physician's order dated 03/02/2016 for daily blood pressure for 14 days and record on MAR.

Review of Resident #3's February 2016 electronic Medication Administration Records (eMARs) revealed:
-There was no documentation for blood pressure or pulse readings.
-There was no entry on the eMAR for the blood pressure or pulse to be obtained and documented.

Review of Resident #3's March 2016 eMAR's for blood pressure and pulse readings revealed:
-On 03/02/2016 at 2:00pm, Resident #3's blood pressure was documented as 126/84 and the pulse rate was 78.
-On 03/09/2016 at 2:00pm, Resident #3's blood pressure was documented as 114/93 and the pulse rate was 151.
-On 03/16/2016 at 2:00pm, Resident #3's blood pressure was documented as 106/91 and the pulse rate was 142.
-There were no other blood pressures or pulse rates recorded for Resident #3.

(According to the National Institute of Health, a person is considered hypertensive if the systolic blood pressure is 140 or higher and diastolic is 90 or higher. According to the National Institute of Health, 60 - 100 beats per minute is considered a normal heart rate).

Review of Care Notes for Resident #3 dated

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02/28/2016 through 03/22/2016 revealed:
-There was no documentation of any blood pressures.
-There was no documentation of any pulse rates.

Interview with the Resident Care Coordinator (RCC) on 03/22/2016 at 4:10pm revealed:
-All vital signs were recorded on the eMAR's.
-The Medication Aide (MA) was responsible to obtain and document vital signs.
-Any blood pressure or vital signs documented on the eMAR would also print on the treatment record (TAR).

Interview with a MA working on 03/23/2016 at 1:45pm revealed:
-The MA had never checked Resident #3's blood pressure or pulse rate.
-The MA usually worked the 3rd shift (11pm to 7am).
-The MA had only been working at the facility since the end of February 2016.

Interview with the Primary Care Provider (PCP) on 03/23/2016 at 3:25pm revealed:
-The PCP had not received any blood pressure readings for the 14 day periods the blood pressures had been ordered for.
-The PCP reordered the blood pressure checks because the blood pressures were not done the first time ordered.
-The PCP believed the resident had been started on a new medication and wanted to monitor the effects of the medication.

b. Review of physician orders for Resident #3 revealed:
-There was a physician's order dated 02/02/2016 for daily finger stick blood sugar (fsbs) checks.
-There was a physician's order dated 02/28/2016

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for blood sugar checks twice daily following a hospital emergency room visit for hyperglycemia.

Further review of Resident #3's record revealed Resident #3 had an emergency room visit on 03/01/2016 for hyperglycemia.

Review of Resident #3's care plan dated 02/16/2016 revealed Resident #3 was assessed to be fully dependent for blood glucose monitoring.

Review of Resident #3's February 2016 eMAR's and TARs revealed:
-There was no documentation for finger stick blood sugar (fsbs) results.
-There was no transcription of an order for daily fsbs checks.
-There was no transcription of an order for twice daily fsbs checks.
-There was a transcription on the February 2016 TARs as follows: "DC'd; Mon, Wed, Fri before breakfast; Tues, Thrs, Sat, Sun, at 2pm; FSBS less than 40 and patient is awake give 1 cup of juice, recheck the blood glucose 15 minutes after the juice and notify the doctor; FSBS 40-60 give 1 cup of juice and notify the doctor; FSBS 61-80 give ½ cup of juice; FSBS of 451 or more call the doctor; if low blood sugar and unresponsive call EMS and notify the doctor ".

Review of February 2016 Care Notes for documentation of finger stick blood sugar results for Resident #3 revealed:
-There were no Care Notes documented prior to 02/28/2016.
-On 02/28/2016 at 6:20am staff documented resident's fsbs was 425 after resident went to MA and stated how he felt.
-The 02/28/2016 6:20am care note did not state

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exactly what the resident said to staff regarding how he felt.
-The 02/28/2016 6:20am care note documented the resident stated he fell during the night.

Interview with the RCC on 03/23/2016 at 12:55pm revealed:
-Blood sugar results were recorded on the eMAR's.
-The MA was responsible to obtain and document finger stick blood sugar results.
-Any blood sugar results documented on the eMAR would also print on the treatment record (TAR).
-The RCC had reviewed the TAR and it looked like the finger stick blood sugars had not been checked for Resident #3 during the month of February 2016.
-Resident #3's fsbs was now being checked morning, lunch, and supper.

Interview with a Medication Aide (MA) on 03/24/2016 at 3:20pm revealed:
-The MA remembered checking Resident #3's blood sugar and administering insulin when it was high.
-The MA could not provide exact dates for fsbs checks.

Interview with the Primary Care Provider (PCP) on 03/23/2016 at 3:25pm revealed:
-The PCP remembered getting calls about Resident #3's fsbs but did not remember exact dates.
-The PCP did not remember if she had reviewed blood sugar results for February 2016 but would check back in her records.

2. Review of Resident # 2's current FL-2 dated

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D 276	Continued From page 10 3/2/16 revealed: -Diagnoses of Osteoarthritis, A, Chronic Kidney Disease, Benign Prostatic Hyperplasia, Hypertensive Disorder, COPD, GERD, Anxiety, Peripheral Vascular Disease and Gastrointestinal Hemorrhage. -An order for blood pressure to be checked daily. Review of Resident Register revealed Resident # 2 was admitted to the facility on 2/9/16. Review of the March 2016 Medication Administration Record (MAR) for Resident # 2 revealed blood pressures were being checked weekly and recorded on the MAR as follows: -On 03/01/2016 at 1:00pm, blood pressure reading of 136/68. -On 03/08/2016 at 1:00pm, blood pressure reading of 133/79. -On 03/15/2016 at 1:00pm, blood pressure reading of 115/64. -On 03/22/2016 at 12:44pm, blood pressure reading of 127/80. Interview with the RCC on 3/23/16 at approximately 11:15 am revealed: -She was unaware that Resident # 2's blood pressure was ordered to be checked daily. -Resident # 2's blood pressure was ordered to be checked weekly. -She had missed the order change on Resident #2's current FL-2. -It was her responsibility to ensure that any new orders were transcribed to the MAR. Interview with a MA on 3/23/16 at 11:20 am revealed: -She had not been checking Resident # 2's blood pressure daily. -She had been checking Resident # 2's blood	D 276		

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pressure weekly and was unaware of an order change to check it daily.
-It was the RCC's responsibility to make sure any new orders were updated on the MAR.

Interview with Resident #2 on 3/23/16 at 11:30 am revealed:
-No one checked his blood pressure daily.
-Sometimes staff would check his blood pressure.

Interview with the facility medical provider on 3/23/16 at 3:40 pm revealed:
-Her intention was for staff to check Resident #2's blood pressure weekly and record it on the MAR.
-She signed the current FL-2 but overlooked the order for the blood pressure to be checked daily.
-She stated that she would write a new order today for the blood pressure to be checked weekly.

Record review of a physician's order dated 02/16/2016 for Resident #2 revealed a physician's order for Resident #2's weight to be checked weekly and recorded on the MAR.

Review of the February 2016 eMAR for Resident #2 revealed no documented weights for Resident #2.

Interview with Resident #2 on 3/23/16 at approximately 11:30 am revealed he had never been weighed at the facility.

Interview with the Resident Care Coordinator (RCC) on 3/23/16 at 11:45 am revealed:
-The wheelchair scale at the facility were broken and there was no way to weigh Resident #2.
-No other attempts had been made to weigh Resident #2.

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D 276	Continued From page 12 Observation of the wheelchair scales on 3/24/16 revealed the ramp for the scale was missing and the scale was not stable enough to support a wheelchair. Interview with the Regional Director on 3/24/16 at 3:30 pm revealed: -New wheelchair scale had been ordered and should be at the facility on 3/25/16. -She had not been informed that the facility needed a new wheelchair scale. 3. Review of Resident #1's current FL2 dated 03/09/16 revealed: -A diagnoses list that included acute/chronic respiratory distress, diabetes, hospital acquired pneumonia, chronic anemia, recurrent deep vein thrombosis, history of pancytopenia, anxiety, status post mitral valve repair, altered mental status, tobacco user, coronary arteriosclerosis, history of lung cancer, and history of psychotic disorder. - There was an order for finger stick blood sugar (FSBS) checks before meals and at hour of sleep. Review of Resident #1's Resident Register revealed an admission date of 02/02/16. Review of a subsequent physician order dated on 03/16/16 to start on 03/17/16 revealed: -There was an order to check FSBS before breakfast, lunch, and supper and enter this glucose level for the sliding scale insulin to be given after a subsequent meal. -There was an order for Novolog Sliding Scale Insulin (Novolog is a fast acting injectable medication used to help lower blood sugar levels in diabetics) three times a day to be given right after breakfast, lunch and supper as follows:	D 276		

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0-150 = no insulin, 151-200 = 4 units, 201-250 = 6 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 12 units, 401-450 = 15 units, 451 or more = 15 units and to call the doctor
-There was an order if the resident ate less than half of any meal, then hold that dose of sliding scale insulin.
-There was an order for finger stick blood sugar of 61-80 give one ½ cup of juice; for finger stick blood sugar of 40-60 give one cup of juice and notify the doctor; for finger stick blood sugars less than 40 and awake, give 1 cup of juice, recheck the blood sugar 15 minutes after the juice and notify the doctor; If the patient has a low blood sugar and unresponsive call EMS (Emergency Medical Services) and notify the doctor.

Review of Residents #1's prior FL-2 dated 02/05/16 revealed an order for finger stick blood sugar checks before meals and at hour of sleep.

Review of a subsequent physician's order dated 02/16/16 revealed:
-There was an order to check finger stick blood sugars before breakfast, lunch, and supper and to enter this glucose level for the sliding scale insulin to be given after a subsequent meal.
-There was an order for Novolog Sliding Scale Insulin three times a day to be given right after breakfast, lunch and supper as follows: 0-150 = no insulin, 151-200 = 4 units, 201-250 = 6 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 12 units, 401-450 = 15 units, 451 or more = 15 units and to call the doctor
-There was an order if the resident ate less than half of any meal, then hold that dose of sliding scale insulin.
-There was an order for finger stick blood sugar of 61-80 give one ½ cup of juice; for finger stick blood sugar of 40-60 give one cup of juice and

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notify the doctor; for finger stick blood sugars less than 40 and awake, give 1 cup of juice, recheck the blood sugar 15 minutes after the juice and notify the doctor; If the patient has a low blood sugar and unresponsive call EMS and notify the doctor.

Review of Resident #1's February 2016 EMAR (Electronic Medication Administration Record) as of 02/18/16 revealed:
-There was an entry to perform a finger stick blood sugar three times a day before meals and dose per sliding scale with Novolog Flexpen injection (Novolog Flexpen is an injectable fast acting medication that comes in a prefilled pen to help lower blood sugar levels) as follows: 0-150 = 0 units; 151-200 = 4 units; 201-250 = 6 units; 251-300 = 8 units; 301-350 = 10 units; 351 - 400 = 12 units; 401-450 = 15 units; 451 or more = 15 units and call the doctor.
-There were entry times to administer the sliding scale at 8:00am, 12:00pm and 5:00pm
- On 02/18/16 the MA entered her initials by the entry for 12:00pm, the row for site administration of the insulin was blank, there was entry for blood glucose as 0; and insulin amount given was 0.
-There were no exceptions documented for 2/18/16 at 12:00pm.
-On 02/18/16 the MA entered her initials by the entry for 5:00pm, the row for site administration of insulin was blank; there was an entry for blood glucose as 0; and insulin amount given was 0.
-There were no exceptions documented for 2/18/16 at 5:00pm.
-On 02/19/16 the MA entered her initials by the entry for 8:00am, the row for site administration of insulin was blank; there was an entry for blood glucose as 0; and insulin amount given was 0.
-There was an exception documented for this order dated 02/16/16 that patient refused on

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D 276	Continued From page 15 2/19/16 at 9:03am. -On 02/19/16 the MA entered her initials by the entry for 12:00pm, the row for site administration of insulin was blank; there was an entry for blood glucose as 0; and insulin amount given was 0. -There was an exception documented for this order dated 02/16/16 that patient refused on 2/19/16 at 11:50am. -On 02/19/16 the MA entered her initials by the entry for 5:00pm, the row for site administration of insulin was blank; there was an entry for blood glucose as 0; and insulin amount given was 0. -There were no exceptions documented for 2/19/16 at 5:00pm. -On 02/20/16 the MA entered her initials by the entry for 8:00am, an entry of N for site administration of insulin; there was an entry for blood glucose of 128; and insulin amount given was 0. -On 02/20/16 the MA entered her initials by the entry for 12:00pm, an entry of N for site administration of insulin; there was an entry for blood glucose of 150; and insulin amount given was 0. -On 02/20/16 the MA entered her initials by the entry for 5:00pm, an entry of L for site administration of insulin; there was an entry for blood glucose of 128; and insulin amount given was 0. -On 02/21/16 the MA entered her initials by the entry for 8:00am, an entry of N for site administration of insulin; there was an entry for blood glucose of 96; and insulin amount given was 0. -On 02/21/16 the MA entered her initials by the entry for 12:00pm, an entry of N for site administration of insulin; there was an entry for blood glucose of 99; and insulin amount given was 0. -On 02/21/16 the MA entered her initials by the	D 276		

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entry for 5:00pm, an entry of N for site administration of insulin; there was an entry for blood glucose of 118; and insulin amount given was 0.
-On 02/22/16 the MA entered her initials by the entry for 8:00am, an entry of N for site administration of insulin; there was an entry for blood glucose of 140; and insulin amount given was 0.
-On 02/22/16 the MA entered her initials by the entry for 12:00pm, an entry of N for site administration of insulin; there was an entry for blood glucose of 114; and insulin amount given was 0.
-On 02/22/16 the MA entered her initials by the entry for 5:00pm, an entry of N for site administration of insulin; there was an entry for blood glucose of 150; and insulin amount given was 0.

Review of Resident #1's February 2016 Electronic Medication Administration Record (EMAR) as of 02/16/16 revealed:
- There was documentation under the exceptions that Resident #1 was hospitalized from 02/23/16 to 02/29/16.
-There were no computerized entries on the February 2016 MAR to enter glucose level for the sliding scale insulin to be given after a subsequent meal on the MAR.
-There was no documentation to indicate intake of subsequent meals.
-There were no computerized entries on the February MAR for a finger stick blood sugar of 61-80 give one ½ cup of juice; for finger stick blood sugar of 40-60 give one cup of juice and notify the doctor; for finger stick blood sugars less than 40 and awake, give 1 cup of juice, recheck the blood sugar 15 minutes after the juice and notify the doctor; If the patient has a low blood

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D 276	Continued From page 17 sugar and unresponsive call EMS (Emergency Medical Services) and notify the doctor. Review of Resident #1's March 2016 EMAR (Electronic Medication Administration Record) revealed: -There were no blood sugars recorded from 03/10/16 through 03/17/16. -There was a computerized entry dated 03/18/16 to check finger stick blood sugars three times a day after breakfast 8:30pm, lunch 1230pm, and supper 5:30pm and dose as follows: 0-150 = 0 units; 151-200 = 4 units; 201-250 = 6 units; 251-300 = 8 units; 301-350 = 10 units; 351-400 = 12 units; 401-450 = 15 units; 451 or more = 15 units and call the doctor. - On 03/18/16 the MA entered her initials by the entry for 5:30pm; site of administration right; there was an entry for blood glucose of 148; there was no row for insulin amount given. -On 03/19/16 the MA entered her initials by the entry for 8:30am; site of administration N; there was an entry for blood glucose of 136, there was no row for insulin amount given. -On 03/19/16 the MA entered her initials by the entry for 12:30pm; site of administration N; there was an entry for blood glucose of 115, there was no row for insulin amount given. -On 03/19/16 the MA entered her initials by the entry for 5:30pm; site of administration left; there was an entry for blood glucose of 124, there was no row for insulin amount given. -On 03/20/16 the MA entered her initials by the entry for 8:30am; site of administration right; there was an entry for blood glucose of 207, there was no row for insulin amount given. -On 03/20/16 the MA entered her initials by the entry for 12:30pm; site of administration N; there was an entry for blood glucose of 79, there was no row for insulin amount given.	D 276		

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D 276	Continued From page 18 -On 03/20/16 the MA entered her initials by the entry for 5:30pm; site of administration left; there was an entry for blood glucose of 126, there was no row for insulin amount given. -On 03/21/16 the MA entered her initials by the entry for 8:30am; site of administration right; there was an entry for blood glucose of 168, there was no row for insulin amount given -On 03/21/16 the MA entered her initials by the entry for 12:30pm; site of administration left; there was an entry for blood glucose of 168, there was no row for insulin amount given. -On 03/21/16 the MA entered her initials by the entry for 5:30pm; site of administration right; there was an entry for blood glucose of 228, there was no row for insulin amount given. -On 03/22/16 the MA entered her initials by the entry for 8:30am; site of administration N; there was an entry for blood glucose of 107, there was no row for insulin amount given. -On 03/22/16 the MA entered her initials by the entry for 12:30pm; site of administration N; there was an entry for blood glucose of 140, there was no row for insulin amount given. -On 03/22/16 the MA entered her initials by the entry for 5:30pm; site of administration N; there was an entry for blood glucose of 133, there was no row for insulin amount given. -On 03/23/16 the MA entered her initials by the entry for 8:30am; site of administration left arm; there was an entry for blood glucose of 177, there was no row for insulin amount given. -On 03/23/16 the MA entered her initials by the entry for 12:30pm; site of administration left; there was an entry for blood glucose of 126, there was no row for insulin amount given. -On 03/23/16 the MA entered her initials by the entry for 5:30pm; site of administration right; there was an entry for blood glucose of 114, there was no row for insulin amount given.	D 276		

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D 276	Continued From page 19 -There were no exceptions entered for the Novolog sliding scale and finger stick blood sugars from 03/18/16 through 03/23/16. Review of Resident #1's March 2016 TAR revealed: -There were no blood sugars recorded from 03/10/16 through 03/17/16. -There was a computerized entry dated 03/18/16 to check finger stick blood sugars three times a day before breakfast 7:30am, before lunch 11:30am, and before supper 4:30pm. -There was a computerized entry to enter glucose level for the sliding scale insulin to be given after a subsequent meal initialed by MA's from 03/18/16 through 03/22/16. -There was a computerized entry for Novolog Sliding Scale Insulin three times a day to be given right after breakfast, lunch and supper; If resident ate less than one half of any meal, then hold that dose of sliding scale insulin. -There was an entry for finger stick blood sugar of 61-80 give one ½ cup of juice; for finger stick blood sugar of 40-60 give one cup of juice and notify the doctor; for finger stick blood sugars less than 40 and awake, give 1 cup of juice, recheck the blood sugar 15 minutes after the juice and notify the doctor; If the patient has a low blood sugar and unresponsive call EMS and notify the doctor; the MA ' s entered initials from 03/18/16 through 03/22/16. -There were no exceptions entered for the Novolog sliding scale and finger stick blood sugars from 03/18/16 through 03/22/16. -There was no documentation to indicate a percentage amount of a subsequent meal eaten by Resident #1. Interview with the RCC (Resident Care Coordinator) on 03/23/16 revealed there were no	D 276		

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D 276	Continued From page 20 additional documents for medication administration orders or a TAR (Treatment Administration Record) for February 2016 for Resident #1. Interview with a MA on 03/24/16 at 2:30pm revealed: -There were two personal care aides assigned to monitor food intake during each meal. -The MA's were are also responsible to observe the residents food intake during meals. -If the MA had to leave the dining area during meal time, it was the responsibility of the personal care aide to report the amount of the meal the residents ate to the MA. -There was not a form designated to record the food intake amount for residents. -There was not a list provided to personal care aides of diabetic residents who would require monitoring of meal intake. _____ Review of the Plan of Protection submitted by the facility on 03/30/2016 revealed: -The facility had immediately put into place a bucket tracking form as of 03/30/2016 to make sure that all physicians orders are carried out correctly and on time. -Staff have been shown how to use the form. -The Administrator will check all orders daily to confirm that all orders are carried out and administered as ordered. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 8, 2016.	D 276		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service	D 309		

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D 309	Continued From page 21 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to maintain an accurate and current listing of 2 of 5 residents (Resident #1, Resident #2) with physician ordered therapeutic diets. The findings are: 1. Review of Resident #1's current FL-2 dated 3/9/16 revealed: -Diagnoses includedAcute Chronic Respiratory Distress, Diabetes Mellitus, Hospital Acquired Pneumonia, Chronic Anemia, Recurrent DVTs, History of Pancytopenia, Anxiety, S/P Mitral Valve Repair, Altered Mental Status, Tobacco User, Coronary Arteriosclerosis, History of Lung Cancer, History of Psychiatric Disorder. -An order for a Cardiac/Diabetic diet. Review of the modified diet list posted in the kitchen revealed Resident #1 was on a Regular diet. Review of the current diets offered by the facility revealed the facility offered Regular, No added table salt, Mechanical Soft, Pureed, and Fat Free diets. Interview with the Dietary Manager on 3/23/16 at 11:40 am revealed: -He kept a binder in the kitchen with all of the	D 309		

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D 309	Continued From page 22	D 309		

current diet orders for all of the residents.
-The most current diet order for Resident #1 was for a Regular diet dated 2/16/16 according to the information that was provided to him.
-The facility does not offer a Cardiac/Diabetic diet and residents with those diet orders should not be admitted unless their doctor can change the diet order to one that the facility offers.

Interview with the Administrator on 3/23/16 at 11:50 am revealed:
-The facility does not offer a Cardiac/Diabetic diet.
-Normally the medical provider for the resident reviewed the diets offered by the facility and chose the appropriate diet for the resident.
-She did not know why Resident #1's diet order had not been changed to one that was offered by the facility.

2. Review of Resident # 2's current FLs-2 dated 3/2/16 revealed:
-Diagnoses included Osteoarthritis, A, Chronic Kidney Disease, Benign Prostatic Hyperplasia, Hypertensive Disorder, COPD, GERD, Anxiety, Peripheral Vascular Disease and Gastrointestinal Hemorrhage.
-An order for a Cardiac diet.

Review of the modified diet list posted in the kitchen revealed Resident #2 was on a Regular diet / No added table salt diet.

Review of the current diets offered by the facility revealed the facility offered Regular, No added table salt, Mechanical Soft, Pureed, and Fat Free diets.

Interview with the Dietary Manager on 3/23/16 at 11:40 am revealed:

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D 309	Continued From page 23 -He kept a binder in the kitchen with all of the current diet orders for all of the residents. -The most current diet order for Resident # 2 was for a Regular/No added table salt diet dated 2/16/16 according to the information that was provided to him. -The facility did not offer a Cardiac diet and residents with those diet orders should not be admitted unless their doctor can change the diet order to one that the facility offers. An interview with the Administrator on 3/23/16 at 11:50 am revealed: -The facility does not offer a Cardiac diet. -Normally the medical provider for the resident reviewed the diets offered by the facility and chose the appropriate diet for the resident. -She did not know why Resident # 2's diet order had not been changed to one that was offered by the facility.	D 309		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to serve the therapeutic diet ordered by the physician for 3 of 6 sampled residents (Residents #1, #2, #4). The findings are:	D 310		

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D 310	Continued From page 24 1. Review of Resident #1's current FL-2 dated 3/9/16 revealed: -Diagnoses included Acute Chronic Respiratory Distress, Diabetes Mellitus, Hospital Acquired Pneumonia, Chronic Anemia, Recurrent DVTs, History of Pancytopenia, Anxiety, S/P Mitral Valve Repair, Altered Mental Status, Tobacco User, Coronary Arteriosclerosis, History of Lung Cancer, History of Psychiatric Disorder. -An order for a Cardiac/Diabetic diet. Review of the modified diet list posted in the kitchen revealed Resident #1 was on a Regular diet. Review of the current diets offered by the facility revealed the facility offered Regular, No added table salt, Mechanical Soft, Pureed, and Fat Free diets. Interview with the Dietary Manager on 3/23/16 at 11:40 am revealed: -He kept a binder in the kitchen with all of the current diet orders for all of the residents. -The most current diet order for Resident #1 was for a Regular diet dated 2/16/16 according to the information that was provided to him. -The facility does not offer a Cardiac/Diabetic diet and residents with those diet orders should not be admitted unless their doctor can change the diet order to one that the facility offers. Interview with the Administrator on 3/23/16 at 11:50 am revealed: -The facility does not offer a Cardiac/Diabetic diet. -Normally the medical provider for the resident reviewed the diets offered by the facility and chose the appropriate diet for the resident.	D 310		

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D 310	Continued From page 25 -She did not know why Resident #1's diet order had not been changed to one that was offered by the facility. Observation of the noon meal on 3/22/16 revealed Resident #1 was served a meal according to a regular diet menu. 2. Review of Resident # 2's current FLs-2 dated 3/2/16 revealed: -Diagnoses included Osteoarthritis, A, Chronic Kidney Disease, Benign Prostatic Hyperplasia, Hypertensive Disorder, COPD, GERD, Anxiety, Peripheral Vascular Disease and Gastrointestinal Hemorrhage. -An order for a Cardiac diet. Review of the modified diet list posted in the kitchen revealed Resident #2 was on a Regular diet / No added table salt diet. Review of the current diets offered by the facility revealed the facility offered Regular, No added table salt, Mechanical Soft, Pureed, and Fat Free diets. Interview with the Dietary Manager on 3/23/16 at 11:40 am revealed: -He kept a binder in the kitchen with all of the current diet orders for all of the residents. -The most current diet order for Resident # 2 was for a Regular/No added table salt diet dated 2/16/16 according to the information that was provided to him. -The facility did not offer a Cardiac diet and residents with those diet orders should not be admitted unless their doctor can change the diet order to one that the facility offers. An interview with the Administrator on 3/23/16 at	D 310		

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D 310	Continued From page 26 11:50 am revealed: -The facility does not offer a Cardiac diet. -Normally the medical provider for the resident reviewed the diets offered by the facility and chose the appropriate diet for the resident. -She did not know why Resident # 2's diet order had not been changed to one that was offered by the facility. Observation of the noon meal on 3/22/16 revealed Resident # 2 was served a meal according to a regular diet menu with no salt on the table. 3. Review of Resident # 4's current FL-2 dated 1/29/16 revealed: -Diagnoses included Gangrene of third toe, Hypertension, Chronic Alcohol Abuse, History of Polysubstance Abuse, and Peripheral Vascular Disease. -An order for a No Added Table Salt diet. Observation of the noon meal on 3/22/16 revealed: -Resident # 4 had 3 individual salt packets and was adding salt to his meal. -There was no additional salt on the table. Interview with Resident # 4 on 3/22/16 during the noon meal revealed: -He got the additional salt from the top drawer in the buffet. -The food needed some salt. Interview with the Dietary Manager on 3/22/16 at approximately 12:15 pm revealed: -The facility provided individual salt packets to residents that requested salt. -The individual salt packets were kept inside of a drawer in a buffet in the dining room.	D 310		

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D 310	Continued From page 27 -Cafeteria staff would have to give residents the additional salt packets. Interview with a Personal Care Aide (PCA) on 03/22/16 assisting dietary staff in serving the residents revealed: -Resident # 4 had asked her for the additional salt packets and she had given them to him. -She stated that she was unaware that Resident # 4 was not supposed to have additional salt. -She stated she thought that she was supposed to give the Residents salt and other condiments if they requested them. Interview with the Administrator on 3/22/16 at 4:00 pm revealed she thought if the residents asked for additional condiments, staff had to accommodate them so as not to violate their resident rights.	D 310		
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 observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed	D 358		

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prescribing practitioner and in accordance with the facility's policies and procedures for 2 of 6 residents (Residents #1 and #3) observed during the medication passes, including errors with insulin administration, and 2 of 3 residents (Residents #2 and #3) sampled for record review, including errors with insulin administration and topical creams.

The findings are:

1. The medication error rate was 7% as evidenced by 2 errors out of 28 opportunities during the 12:00pm medication pass on 03/22/2016, the 4:00pm medication pass on 03/22/2016, and the 8:00am medication pass on 03/23/2016.

a. Review of Resident #3's current FL-2 dated 02/02/2016 revealed diagnoses included hypertension, hyperlipidemia, morbid obesity, mild mental retardation, chronic paranoid schizophrenia, and diabetes mellitus type II.

Review of physician orders for Resident #3 revealed:
-There was a physician's order dated 02/02/2016 for finger stick blood sugar (fsbs) checks daily.
-There was a physician's order dated 02/28/2016 for fsbs checks two times a day.
-There was a physician's order dated 03/02/2016 for fsbs checks daily Monday, Wednesday, Friday before breakfast, and Tuesday, Thursday, Saturday, Sunday at 2pm. For fsbs of 500 or more call doctor; 61-80 give ½ cup of juice; for fsbs 40-60 give 1 cup of juice and notify doctor; for fsbs less than 40 and patient is awake give 1 cup of juice, recheck the blood glucose 15 minutes after the juice and notify the doctor; if patient has a low blood sugar and is

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unresponsive call EMS [emergency medical service] and notify the doctor.
-There was a physician's order dated 03/03/2016 to discontinue all previous blood glucose checks; blood glucose check before meals and "q" [every] 06:30am, q 11:30am, q 4:30pm; Humalog (a fast acting injectable medication used to lower blood sugars) sliding scale 3 times daily injection for above sugars to be given right after meals.
0-150: no insulin, 151-200: 4 units, 201-250: 6 units, 251-300: 8 units, 301-350: 10 units, 351-400: 12 units, 401-450: 15 units, 451 or more: 15 units and call the doctor. If the resident eats less than half of any meal, then hold that dose of sliding scale insulin. For blood glucose of 61-80 give ½ cup of orange juice; for fsbs 40-60 give 1 cup of orange juice and notify doctor; for fsbs less than 40 and patient is awake give 1 cup of orange juice and check the blood glucose 15 minutes after the juice and notify the doctor; if the patient has a low blood sugar and is unresponsive call EMS and notify the doctor.

Observation of the medication pass on 03/22/2016 at 12:03pm revealed:
-The Medication Aide (MA) performed a fsbs check for Resident #3.
-Resident #3's fsbs results were observed to be 182.
-The MA informed Resident #3 he would "have to get a shot".
-The MA prepared Humalog Insulin 4 units and injected the insulin into the right upper arm of Resident #3 at 12:08pm.
-Resident #3 was instructed by the MA to go down to the dining room for lunch.
-Resident #3 proceeded to the dining room and was observed eating at 12:10pm.

Review of Resident #3's electronic Medication

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Administration Records (eMARs) for March 2016 revealed:
-There was an entry for fsbs checks at 6:30am, 11:30am, and 4:30pm printed to the eMARs with documentation of fsbs 03/04/2016 through 03/18/2016.
-There was documentation that the order had been "SUSPENDED 18 MAR 2016".
-There was a second entry for Humalog insulin injections which included fsbs three times daily before meals and dose per sliding scale right after meals with documentation of amount given, site, and fsbs results timed for 8:30am, 12:30pm, and 5:30pm from 03/03/2016 through 03/22/2016.

Interview with the MA on 03/22/2016 at 12:55pm revealed:
-The MA performed the fsbs check for Resident #3 before meals.
-Resident #3 "can get his insulin right after meals".
-Resident #3 was supposed to have insulin administered three times daily right after meals.
-Resident #3's orders had changed many times.
-The MA administered the insulin on 03/22/2016 at the meal time because she was "distracted, nervous."
-Resident #3 usually was administered insulin after meals.

Interview with the Medication Aide (MA) on 03/23/2016 at 8:00am revealed:
-The MA had already administered Resident #3's medication.
-The MA would check Resident #3's fsbs after Resident #3 ate breakfast.
-The instructions on the eMAR were to check Resident #3's fsbs before meals but instructions regarding time were for 8:30am.

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-The MA thought she should perform the fsbs before Resident #3 ate, but the MA did not have anywhere to record the fsbs before 8:30am.
-The MA administered medications at the times printed on the eMAR.
-The MA would check with the Resident Care Coordinator (RCC) as suggested about checking Resident #3's fsbs.

Observation of the MA on 03/23/2016 between 8:05am and 8:07am revealed:
-The MA called Resident #3 out of the dining room at 8:05am.
-The MA took Resident #3 into the medication room and performed the fsbs.
-Resident #3 returned to the dining room after the fsbs was performed.
-Resident #3 was served his breakfast beverages at 8:10am.

b. Review of Resident #1's current FL-2 dated 02/05/2016 revealed diagnoses included lung cancer, oxygen dependent, hypertension, anxiety, depression, history of deep vein thrombosis, anemia, and diabetes mellitus.

Interview with Resident #1 on 03/23/2016 at 8:35am revealed Resident #1 had already eaten breakfast.

Observation of the medication pass on 03/23/2016 from 8:40am to 8:50am revealed:
-The Medication Aide (MA) performed a fsbs check for Resident #1.
-Resident #1's fsbs result was observed to be 177.
-The MA stated Resident #1 would be administered Novolog Flexpen Insulin 4 units according to the prescribed sling scale.
-The MA prepared Novolog Insulin 4 units and

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injected the insulin into the left upper arm of Resident #1 at 8:44am.

Interview with the MA on 03/23/2016 at 8:50am revealed:
-Resident #1 was supposed to be administered Lantus Insulin 10 units every morning at 8am.
-The MA was not going to administer the Lantus Insulin to Resident #1 "because I missed it, it's too late to give it now, supposed to get it at 8am, can't mix the insulin".
-The MA stated she usually worked the 3rd shift and not the 1st shift and did not give the Lantus on the 3rd shift.
-She would contact the Resident Care Coordinator for clarification on administering the Lantus insulin.

Immediate observation of the MA and RCC on 03/23/2016 revealed:
-The MA called the RCC to the medication cart.
-The RCC approached the medication cart and reviewed Resident #1's eMAR instructions.
-The RCC told the MA she would get clarification from the physician.
-The MA did not administer the Lantus Insulin to Resident #1 at that time.

Interview with the RCC on 03/23/2016 at 9:20am revealed:
-The RCC had contacted the physician and the PCP.
-The PCP wanted Resident #1 to be administered the Lantus insulin as ordered.
-Resident #1 was supposed to have been administered the Lantus insulin at 8am.
-Resident #1 was supposed to have been administered the Lantus insulin before she ate.
-A medication error report would be completed.

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D 358	Continued From page 33 Observation of the MA on 03/23/2016 at 9:40am revealed: -The MA approached Resident #1 and prepped the resident's left upper arm for administration of Lantus Insulin 10 units subcutaneously. -The MA stopped after surveyor asked the MA about rotating sites for insulin administration. -The MA stated she usually rotated sites when administering insulin. -The MA then prepped the right upper arm and administered Lantus insulin 10 units subcutaneously. Review of physician orders for Resident #1 revealed: -There was a physician's order dated 03/17/2016 for finger stick blood sugar (fsbs) checks before breakfast, lunch, and supper. Enter this glucose level for the sliding scale insulin to be given after the subsequent meal. -There was a physician's order dated 03/09/2016 for Lantus (a long acting injectable medication used to treat lower blood sugars in diabetics) 10 units subcutaneously daily. Review of Resident #1's electronic Treatment Administration Records (TARs) for March 2016 revealed: -Instructions for fsbs before breakfast, lunch, and supper. Enter this glucose level for the sliding scale insulin to be given after the subsequent meal. -The fsbs's were scheduled for 7:30am, 11:30am, and 4:30pm.. Review of Resident #1's eMARs for March 2016 revealed: -Instructions for Lantus insulin injections included to inject 10 units subcutaneously daily (do not mix with other insulin products).	D 358		

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D 358	Continued From page 34 -The Lantus insulin administration time was scheduled for 8:00am. 2. Review of Resident #3's current FL-2 dated 02/02/2016 revealed diagnoses included hypertension, hyperlipidemia, morbid obesity, mild mental retardation, chronic paranoid schizophrenia, and diabetes mellitus type II. a. Review of physician's orders dated 03/09/2016 revealed a physician's order to start Levemir insulin (used to lower blood sugars in diabetes) 10 units every night at bedtime. Review of the March 2016 eMARs for Resident #3 revealed: -There was no entry transcribed to the eMARs for Levemir insulin. -There was no documentation of administration on the eMARs of Levemir insulin for Resident #3. Interview with the Resident Care Coordinator (RCC) on 03/23/2016 at 12:55pm revealed: -Resident #3 was supposed to be administered Levemir insulin at night. -The RCC knew there was an order for Resident #3 to be administered Levemir. -The RCC had faxed the Levemir order to the pharmacy but did not remember the date but did get a faxed confirmation. -The RCC did not know if the pharmacy received the Levemir order because she had not checked back with the pharmacy. -The RCC was responsible to assure physician orders were on the eMARs. -The pharmacy provider put the orders in the QuikMar. -The RCC had to approve orders before order was released for the MA to administer the medication. -The RCC was responsible to check the EMAR	D 358		

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weekly against the hard copy physician order.
-Levemir insulin should be showing up on the eMAR.
-The RCC did not know if the Levemir insulin was received at the facility from the pharmacy.
-The MA was responsible for receiving medications from the pharmacy and checking the medications against the pharmacy delivery ticket.
-The RCC was responsible to perform medication cart audits weekly.
-The RCC could not provide a date as to when she had completed a medication cart audit at the facility.

Interview with a Medication Aide (MA) on 03/23/2016 at 1:30pm revealed:
-The only insulin Resident #3 was being administered was for a sliding scale.
-The MA thought she had administered Levemir insulin to Resident #3 in the past but did not remember dates.

Interview with the RCC on 03/23/2016 at 1:55pm revealed:
-The RCC had called the pharmacy about the Levemir.
-The RCC refaxed the order to the pharmacy on 03/23/2016.
-The RCC did not have a copy of the original faxed Levemir order to the pharmacy.
-The RCC thought she had a copy of the faxed order.
-The Levemir insulin had not been dispensed from the pharmacy.

Interview with a MA on 03/24/2016 at 3:20pm revealed:
-The MA thought it had been a while since she had administered Levemir insulin to Resident #3.
-The MA remembered administering it in the past

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but did not remember when the Levemir order had changed.

Review of the February 2016 eMARs for Resident #3 revealed no documentation of administration of Levemir insulin since the resident was admitted to the facility on 02/09/2016.

Interview with a Pharmacy Representative on 03/24/2016 at 8:20am revealed:
-The pharmacy received an order from the facility on 03/23/2016 for Levemir Insulin 10 units subcutaneously every night.
-The Levemir order was esigned by the PCP on 03/02/2016.
-The Levemir insulin was dispensed and delivered to the facility on 03/23/2016.
-There had been no Levemir insulin dispensed to the facility prior to 03/23/2016.

Interview with the Primary Care Provider (PCP) on 03/23/2016 at 3:25pm revealed:
-The PCP was not aware the Levemir insulin had not been administered.
-The goal with the Levemir insulin was to discontinue the sliding scale insulin and get an acceptable dose of Levemir to keep Resident #3 a more consistent blood sugar level throughout the day.

b. Review of physician orders for Resident #3 revealed:
-There was an order dated 02/02/2016 for Risperidone (used to treat schizophrenia) 4mg twice a day.
-There was an order dated 03/16/2016 to discontinue Risperdal 4mg two times a daily.
-There was an order dated 03/16/2016 to start Risperdal 3mg two times a day.

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D 358	Continued From page 37 Review of the March 2016 electronic Medication administration records (eMARs) for Resident #3 revealed: -There was documentation of administration of Risperidone 4mg twice daily at 8am and 8pm. -The last dose of Risperidone 4mg was documented as administered on 03/18/2016 at 8am. -There was documentation of administration of Risperidone 3mg twice daily at 8am and 8pm. -The first dose of Risperidone 3mg was documented as administered on 03/18/2016 at 8pm. Review of medications on hand with the Medication Aide on 03/23/2016 at 1:40pm for Resident #3 revealed: -There was a pharmacy dispensed blister pack labeled for Risperidone 3mg tablet take one tablet twice daily for Resident #3. -Risperidone 3mg tablets were dispensed on 03/19/2016. -There was one tablet packaged in each blister labeled for morning. -There were three tablets remaining for the morning dose with the dates for 03/24/2016, 03/25/2016, and 03/26/2016. -There was one tablet packaged in each blister labeled for bedtime. -There were five blister packs with one tablet each remaining for the bedtime dose with the dates for 03/22/2016, 03/23/2016, 03/24/2016, 03/25/2016, and 03/26/2016. -Resperidone 4mg tablets was dispensed on 03/17/2016. -There were ten tablets packaged in each blister labeled for morning, including one Risperidone 4mg tablet. -There were three blister packs remaining for the morning dose with the dates for 03/24/2016,	D 358		

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D 358	Continued From page 38 03/25/2016, and 03/26/2016. -There were five tablets packaged in each blister labeled for bedtime. -There were four blister packs tablets remaining for the bedtime dose with the dates for 03/23/2016, 03/24/2016, 03/25/2016, and 03/26/2016. Interview with a Medication Aide (MA) on 03/23/2016 revealed: -The MA compared the medications in the blister pack to the eMARs when administering medications. -The MA had never removed any medications from the medications in the blister pack before administering the medication to the residents. -The MA was not sure what the procedure was to be used when a medication in a medication packaged with other medications had been changed or discontinued. -The MA thought the packaged medication would need to be returned to the pharmacy. Interview with a Pharmacy Representative on 03/24/2016 at 8:20am revealed: -The pharmacy received an order on 03/18/2016 dated 03/16/2016 to discontinue Resperidone 4mg and start Resperidone 3mg. -The pharmacy packaged the medications for residents at the facility on a weekly schedule. -All medications for a specific time were packaged in one bubble of the blister pack. -If a medication in the bubble had been discontinued, the facility was to discard the pill that had been discontinued. -The facility was supposed to be scanning the medication cards and that lets the MA know what to give and what not to give. -The current order for Resperidone was 3mg twice a day.	D 358		

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D 358	Continued From page 39 Observation of the Medication Aide (MA) on 03/24/2016 at 10:20am revealed: -The MA prepared medications for administration to a resident. -The MA looked at the blister pack and then at the eMAR screen for the resident she was preparing to administer medication. -The MA popped the pills from the blister pack and checked the medication off on the eMAR. -The MA was not observed to scan the packaged medication card. Interview with the MA on 03/24/2016 at 10:25am revealed: -The MA had never used the scanner on the medication cart. -The MA did not know if the scanner on the medication card was hooked up. Interview with a second Medication Aide (MA) on 03/24/2016 at 11:25am revealed: -The MA was used to looking at the medication package. -The MA compared the medication package to the eMAR. -There was a scanner on the medication cart but the MA did not use the scanner. -The MA had used the scanner "a few times" and it had been "maybe 3 -4 weeks ago". -The MA had never removed any medications from the medications in the blister pack before administering the medication to the residents. -The MA would have to call the doctor if the wrong medication was in the medication package. Resident #3 was out of the facility on 03/24/2016 and unavailable for interview.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078095	A. BUILDING: _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE SPRINGS	104 HOPE LANE RED SPRINGS, NC 28377

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D 358	Continued From page 40 Review of the Plan of Protection submitted by the facility on 03/23/2016 revealed: -Facility plan for training of staff on diabetic and insulin administration to be done 03/31/2016 by LHPS nurse and by Corporate M.D. on 03/28/2016. -The Administrator will assure meds ordered and administered by Med Aide and RCC on going everyday. -Immediate training will be done 03/24/2016 on medication administration and completed on all by 03/25/2016. -The Administrator will check orders daily with RCC and confirm meds are ordered and delivered timely and administered as ordered. -Immediate chart audits will be done 03/24/2016. -Charts, med carts, and chart audits will be performed weekly to assure compliance. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 8, 2016.	D 358		
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: Based on observations, interviews and record review, the facility failed ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations	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 41 related to health care and medication administration. The findings are: 1. Based on record review and interview, the facility failed to assure referral of an elevated heart rate and follow up of finger stick blood sugar results according to parameters provided by the licensed practitioner to meet the routine and acute health care needs for 1 of 3 residents (Resident #3) sampled. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 2. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility ' s policies and procedures for 2 of 6 residents (Residents #1 and #3) observed during the medication passes, including errors with insulin administration, and 2 of 3 residents (Residents #2 and #3) sampled for record review, including errors with insulin administration and topical creams. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 3. Based on record review and interview, the facility failed to assure physician's orders for monitoring of pulse rates, blood pressures, weights, finger stick blood sugars, and food intake , were implemented as ordered for 3 of 3 residents (Residents #1, #2, and #3) sampled. [Refer to Tag 276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation)].	D912		