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DIVISION OF HEALTH SERVICE REGULATION
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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
	HAL094006	A. BUILDING: _____ B. WING _____	R 02/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS MANOR	503 WEST BUNCOMBE STREET ROPER, NC 27970

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D 000	Initial Comments The Adult Care Liensure Section conducted an annual survey, follow- up survey, and a complaint investigation on 1/31/17-2/3/17 and 2/6/17-2/7/17.	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 assure medications were administered as ordered for 5 of 12 residents (#5,#8, #9, #10, and #11) observed during the medication pass, including errors with a short acting insulin (#8,9,10), a long acting insulin (#11), and a digestive enzyme (#5). The findings are: The medication error rate was 17% as evidenced by the observation of 5 errors out of 28 opportunities during the medication passes on 2/1/17 and 2/2/17. 1. Review of Resident #8's current FL2 dated 4/6/16 revealed: -Diagnoses included mild mental retardation, hypertension, and hyperlipidemia. -There was physician's order for 36 units of	D 358		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda B. Colby — TITLE: Administrator — (X6) DATE: 3-3-17

Reviewed & accepted
3-13-17 [illegible]

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D 358	Continued From page 1 Humalog Kwikpen (a fast-acting form of insulin that works by lowering levels of glucose (sugar) in the blood); injection three times a day with meals, resident may self-administer with supervision at all times. Review of the Resident Register for Resident #8 revealed he was admitted to the facility on 1/1/15. Review of a Physician order for Resident #8 dated 9/2/16 revealed an increase in Humalog insulin injection 40 units 3 times a day. Observation of the medication pass on 2/1/17 at 11:07am revealed: -The Medication Aide (MA) checked Resident #8's blood sugar at 10:59am, and the result was 180. -Resident #8's blood sugar was collected just prior to insulin administration. - The MA did an air shot and set the dial to 40 units and handed the kwikpen to the resident. -Resident #8 injected himself with 40 units of Humalog, as the MA supervised at 11:07am. Observation of Resident #8 on 2/1/17 between 11:07am and 12:09pm revealed: -Resident #8 was not eating when he injected himself with 40 units of Humalog. -Resident #8 was served lunch at 12:09pm. Review of the February 2017 Electronic Medication Administration Record (EMAR) for Resident #8 revealed Humalog insulin 40 units was scheduled to be administered at 11:30am. Interview with Resident #8 on 2/1/17 at 11:10am revealed he took his insulin when staff prompted him to take it.	D 358	D 358 10A NCAC 13F 1004 (a) Medication Resident # 8 (CM) Insulin was scheduled to be given with meals. Meal time is 12:00. At 11:00 Med Aide pulled up the insulin, due to it popping up on the computer to be given. She passed it to the resident, who prefers to inject it himself and he injected it at 11:07. This order was written by the physician to give with meals. Insulin was given early at 11:07. Med Aide was following the pop-up on the computer instead of reading the entire order. Immediately the physicians were called , to have everyone's orders changed to read, give insulin before meals and NOT with meals. The pharmacy was also called to fix the issue of the orders popping up too early on the screen and to change the orders to read, give insulin before meals and not with meals. This was done during the day of the survey. Please see Exhibit A, enclosed where the physician signed the order. Completion Date : 2-2-17 Mandatory Meeting for training on all insulin issues and Resident Rights 2-13-17.	

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D 358	Continued From page 2 Interview with the MA on 2/1/17 at 1:05pm revealed: -She gave Resident #8 his insulin when it popped up on the screen to be given. -She thought if the medication was ordered with meals it should be given 20 minutes before the meal. -When she saw the medication pop up on the screen she felt "pressed" to give it. -Before the facility got their new Electronic Medication Administration Record (EMAR), she was able to administer the insulin when she did the finger stick, but now she had to wait for the insulin to pop up on the screen to administer. -Resident #8 had eaten breakfast at 8:00am and snack at 10:20am on 2/1/17. Interview with the Assistant Manager on 2/1/17 at 1:15pm revealed: -The MA should have been administering the medications as the order specified. -If the order said to administer with meals the medication should have been administered with the meal. -She would contact the pharmacist about the medications showing up early on the EMAR. -She would also contact Resident #8's physician to see if she could get his insulin order changed to before meals, so that it may be administered 30 minutes before the meal. Interview with the Manager on 2/6/17 at 4:45pm revealed: -She would go through each residents' insulin orders to ensure the insulin was ordered 30 minutes before the meal. -She would get a clarification from the physician to change all insulin orders that specified insulin to be administered with a meal, to be administered 30 minutes before the meal.	D 358		

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D 358	Continued From page 3 -The Assistant Manager had contacted the physician's office and was awaiting a response. -The MAs had been instructed to give insulin ordered with meals, with the corresponding meal time. 2. Review of Resident #5's current FL2 dated 12/9/16 revealed: -Diagnoses included coagulopathy -There was a physician's order for Creon DR 24,000 (a digestive enzyme to help break down and digest fats) 2 capsules three times a day with meals. Review of the Resident Register for Resident #5 revealed he was admitted to the facility on 1/1/15. Observation of the medication pass on 2/1/17 at 11:26am revealed: -The medication aide (MA) administered 2 capsules of Creon DR 24,000 units to Resident #5 at 11:26am. -Resident #5 was not eating when the medication was administered. Review of the February 2017 electronic medication administration record (EMAR) for Resident #5 revealed Creon DR 24,000 units 2 capsules was scheduled to be administered at 12:00pm. Observation of Resident #5 on 2/1/17 at 12:03pm revealed: -Resident #5 stood in the dining room waiting to be served his drink. -The dietary aide poured 2 glasses of tea into a glass for Resident #5. -The resident poured his 2 glasses of tea into his own plastic cup he had brought to the dining room.	D 358		

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D 358	Continued From page 4 -After Resident #5 poured his tea into his cups, he turned and walked out of the dining room without eating. Interview with the MA on 2/1/17 at 1:05pm revealed: -She thought if the medication was ordered with meals it should be given 20 minutes before the meal. -Resident #5 did not eat lunch at the facility. -She gave him his medications as scheduled on the EMAR even if he did not eat. -Most of the time he refused to eat meals and snacks. Interview with Resident #5 on 2/2/17 at 6:15pm revealed: -He did not eat lunch, but he liked to drink tea. -He would go to the dining room and pour his tea into his cup and he would sign himself out of the facility and leave. Interview with the Assistant Manager on 2/1/17 at 1:15pm revealed: -The MA should have been administering the medications as the order specified. -If there was an order to administer with meals, the medication should be administered with the meal. -She would contact the pharmacist about the medications showing up early on the EMAR. -She was going to call Resident #5's physician and let him know the resident regularly refused meals at the facility. Review of a fax correspondence between the facility and the physician dated 2/1/17 revealed: -The facility informed the physician that Resident #5 did not eat breakfast, lunch, and dinner at the facility every day.	D 358	D 358 10A NCAC 13F 1004 (a) Medication Resident # 5 (MT) This order was written by the physician to give the tablet with meals. The med aide gave him the tablet and resident refused to eat. Immediately the physician was called . The new order states, if he does not eat, do not give him the tablet. The pharmacy was also called to fix the issue of the orders popping up too early on the screen and to change the orders to read, do not give tablet if resident does not eat. This was done during the day of the survey. Please see Exhibit B, enclosed where the physician signed the order. Completion Date : 2-2-17 Mandatory Meeting for training on all insulin issues and Resident Rights 2-13-17.	

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D 358	Continued From page 5 -They had a problem because the medication specified it was to be given three times a day with meals. -The physician responded "it says with meals, no meal no medication". Interview with the Manager on 2/6/17 at 4:45pm revealed, the Assistant Manager contacted Resident #5's physician and received an order from the physician allowing the MA to withhold the medication if Resident #5 refused to eat. 3. Review of Resident #10's current FL2 dated 12/16/16 revealed: -Diagnoses included type 2 diabetes, dementia, and hypertension. -Novolog (a fast-acting form of insulin that works by lowering levels of glucose (sugar) in the blood) 100units/ml administer 3 units before lunch and dinner. Review of the Resident Register for Resident #10 revealed he was admitted to the facility on 1/1/15. Observation of the medication pass on 2/1/17 from 10:49am- 11:20am revealed: -Resident #10's blood sugar was collected at 10:48am with a result of 219. -The MA administered 3 units of insulin to Resident #10 at 11:20am. Observation of Resident #10 on 2/1/17 revealed Resident #10 was served lunch at 12:07 and immediately began eating. Refer to interview with the MA on 2/1/17 at 1:05pm: Refer to interview with the Assistant Manager on 12/1/17 at 1:15pm:	D 358	D 358 10A NCAC 13F 1004 (a) Medication Resident # 10 (HM) This order was written by the physician to give insulin with meals. Again the resident received the insulin to early, due to it popping up on the screen of the computer. The physician was called immediately to request the order being changed, to read, give insulin before meals. Please see Exhibit C. The pharmacy was also called to fix the issue of the orders popping up too early on the screen and to change the orders to read, give insulin before meals This was done during the day of the survey. Please see Exhibit C, enclosed where the physician signed the order. Completion Date : 2-2-17 Mandatory Meeting for training on all insulin issues and Resident Rights 2-13-17.	

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D 358	Continued From page 6 Refer to interview with the Manager on 2/6/17 at 4:45pm: Refer to interview with the Administrator on 2/7/17 at 10:40am: 4. Review of Resident #9's current FL2 dated 3/7/16 revealed: -Diagnoses included Diabetes, alcohol dependent, and psychiatric disorder. -There was a physician's order for fasting blood sugar checks with meals and at bedtime. -Novolog Flex pen (a fast-acting form of insulin that works by lowering levels of glucose (sugar) in the blood) 100units/ml, Sliding Scale Insulin (SSI) administer based on the following sliding scale: -Blood sugars 0-200=0units, 201-250= 2 units, 251-300=4 units, 301-350=6units, 351-400= 8 units, 401 and higher=10 units and call the physician or take to the emergency room. -An order for Novolog Flex pen 100units/ml 15 units three times a day prior to meals, do not administer if resident is not eating. Review of the Resident Register for Resident #9 revealed he was admitted to the facility on 1/1/14. Observation of the medication pass on 2/1/17 at 10:52am revealed: -The medication aide (MA) collected Resident #9's blood sugar, with a result of 229. -The MA administered 17 units of Novolog to Resident #10 at 10:52am. Review of the February 2017 Electronic Medication Administration Record (EMAR) for Resident #9 revealed the Novolog insulin 15 units, and the Novolog SSI were scheduled to be administered at 11:30am.	D 358	D 358 10A NCAC 13F 1004 (a) Medication Resident # 9 (GS) This order was written by the physician to give insulin with meals. Again the resident received the insulin too early, due to it popping up on the screen of the computer. The physician was called immediately to request the order being changed, to read, give insulin before meals. Please see Exhibit D. The pharmacy was also called to fix the issue of the orders popping up too early on the screen and to change the orders to read, give insulin before meals This was done during the day of the survey. Please see Exhibit D, enclosed where the physician signed the order. Completion Date : 2-2-17 Mandatory Meeting for training on all insulin issues and Resident Rights 2-13-17.	

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D 358	Continued From page 7 Interview with the MA on 2/1/17 at 11:20am revealed Resident #9's insulin had popped up on the EMAR so she would administer it immediately after checking his blood sugar. Observation of Resident #9 on 2/1/17 revealed Resident #9 was served lunch at 12:07pm and immediately began eating. Refer to interview with the MA on 2/1/17 at 1:05pm: Refer to interview with the Assistant Manager on 12/1/17 at 1:15pm: Refer to interview with the Manager on 2/6/17 at 4:45pm: Refer to interview with the Administrator on 2/7/17 at 10:40am: 5. Review of Resident #11's current FL2 dated 12/14/16 revealed diagnoses included schizoaffective disorder and delusional parasites. Review of the Resident Register for Resident #11 revealed he was admitted to the facility on 1/1/15. Review of a physician order dated 12/14/16 revealed: -There was an order for fasting blood sugar checks to be collected four times a day and administer Levimir 100units/ml (a long-acting insulin used to control high blood sugar) SSI based on the following sliding scale: Blood sugars 150-199=1unit, 200-249= 2 units, 250-299=3 units, 300-349=5units, 350-399= 8 units, if greater than 400, call the physician.	D 358		

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D 358	Continued From page 8 Observation of the medication pass on 2/1/17 at 11:18am revealed: -The medication aide (MA) collected Resident #11's blood sugar with a result of 187. -The MA administered 1 unit of Novolog to Resident #11 at 11:18am. Review of the February 2017 EMAR revealed the Novolog was scheduled to be administered at 12:00pm. Observation of Resident #11 on 2/1/17 at 12:07pm revealed, Resident #11 was severed lunch and began eating immediately. Refer to interview with the MA on 2/1/17 at 1:05pm: Refer to interview with the Assistant Manager on 12/1/17 at 1:15pm: Refer to interview with the Manager on 2/6/17 at 4:45pm: Refer to interview with the Administrator on 2/7/17 at 10:40am: --- Interview with the MA on 2/1/17 at 1:05pm revealed: The residents had each eaten breakfast at 8:00am and snack at 10:20am on 2/1/17. -She administered the residents' insulin "when it popped up on the screen". -The EMAR would allow medications to be administered 1 hour before the scheduled time. -She had diabetes training and had worked as a MA since 2011. -She knew when a physician wrote an order for before meals that meant the medication was to	D 358	D 358 10A NCAC 13F 1004 (a) Medication Resident # 11 (CR) This order was written by the physician correctly. Insulin to be given before meals. However, the resident received the insulin too early, due to it popping up on the screen of the computer. The pharmacy was called to fix the issue of the orders popping up too early on the screen. This was done during the day of the survey. Completion Date : 2-2-17 Mandatory Meeting for training on all insulin issues and Resident Rights 2-13-17.	

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D 358	Continued From page 9 be administered 30 minutes before the meal. -The facility had just recently started using an EMAR system. -When the medication popped up on the screen she felt pressed to administer it, so that it would not appear to be administered late. Interview with the Assistant Manager on 2/1/17 at 1:15pm revealed: -The MA should have been administering the medications as the order specified. -She was aware if the physician order said to administer before meals, the medication especially insulin, should have been administered within 30 minutes of the meal. -She would contact the pharmacist about the medications showing up early on the EMAR. -She wanted the insulin to pop up on the EMAR at the time it should be administered. Interview with the Manager on 2/6/17 at 4:45pm revealed: -Insulin should always be given as close to meal time as possible. -The EMAR system was fairly new and the facility staff was still working out the kinks. -The Assistant Manager had been working with the pharmacy since 2/1/17 to set the times that the medication would pop up on the MAR. -She would monitor each insulin order to ensure they were being administered within 30 minutes of the meal. -The MAs were instructed to give insulin ordered before meals within 30 minutes of the corresponding meal time. Interview with the Administrator on 2/7/17 at 10:40am revealed: -She thought the policy had been to administer medications 1 hour before the residents ate.	D 358		

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D 358	Continued From page 10 -She was not aware the insulin needed to be administered within 30 minutes of the meal. -She would ensure the residents receiving insulin before meals would have their insulin administered just prior to entering the dining room. -She would ensure the diabetic residents would be served before the other resident at each meal.	D 358	Summary: All areas of concern were taken care of before the survey ended. Our computer system is new to us and we are still working out the issues it is purposing in some areas. It in most cases, does a great job. Our medication aides were depending on it, we see, far too much. The orders still have to be read and they have learned they cannot depend totally on what pops up. We had a very extensive training covering all insulin uses. The meeting was mandatory. We are sending as Exhibit E where everyone signed in for the meeting on February 13, 2017. Also we covered resident's rights at the same meeting as a refresher to all employees. Manager will monitor all these issues once a week. Pharmacy is also on top of any issues and will assist us anyway that is needed, to correct any problems we have with the computer system. Total Completion: 2-13-2017	

Linda B. Ashby
Adm.
3-3-17