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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Haywood County Department of Social Services conducted an annual survey on November 1, 2017 through November 2, 2017. | D 000 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure Humalog was administered as ordered for 1 of 2 sampled residents (Resident #1) who had orders for insulin and Glucagon was available for administration.<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 10/19/17 revealed:<br>-Diagnoses included diabetes mellitus, hypertension, anxiety, and rheumatoid arthritis.<br>-An order for Humalog 4 (used to control blood sugar) units daily at breakfast.<br>-An order for Humalog 7 units every day at lunch.<br>-An order for Humalog 6 units every day at | D 358 | Inserviced staff on:<br>1. Placing calculator on EMar to calculate proper insulin dosage.<br>2. Compare all EMar orders with Physician orders for accuracy.<br>3. Report any inaccurate orders to RCC & Pharmacy immediately | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: _____ TITLE: ADMINISTRATOR (X6) DATE: 12/4/17



Reviewed & approved
12/8/17

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supper.
-An order for Humalog per sliding scale before meals using the following scale: 151-200=1 unit; 201-250=2 units; and 251-300=3 units; 301-350=4 units; 351-400=5 units.
-An order for Humalog per sliding scale at bedtime using the following scale: 151-200=none, 201-250=1 unit; 251-300=2 units; 301-350=3 units; and 351-400=4 units.
-FSBS less than 50 delay injection until immediately after meal reduce insulin by 4 units.
-FSBS 51-70 immediately eat take injection just before eating reduce insulin by 2 units.
-FSBS 71-150 take prescribed dose of insulin.
-If unusually vigorous or eating less than usual, decrease Humalog insulin by 1 unit.
-If unusually inactive, or eating more than usual, increase Humalog insulin by 1 unit.
-Fingerstick blood sugar (FSBS) testing before meals and at bedtime.

A. Review of Resident #1's physician order dated 5/19/17 revealed:
-An order for Humalog per sliding scale at bedtime using the following scale: 151-200=none, 201-250=1 unit; 251-300=2 units; 301-350=3 units; and 351-400=4 units.

Review of Resident #1's signed physician order sheets dated 8/22/17 and 9/6/17 revealed:
-An order for Humalog 4 units daily at breakfast.
-An order for Humalog 4 units every day at lunch.
-An order for Humalog 6 units every day at supper.
-An order for Humalog per sliding scale before meals using the following scale: 151-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; and 351-400=5 units.
-An order for Humalog per sliding scale at bedtime using the following scale: 151-200=none,

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| D 358 | Continued From page 2<br>201-250=1 unit, 251-300=2 units; 301-350=3 units; and 351-400=4 units<br>-FSBS less than 50 delay injection until immediately after meal reduce insulin by 4 units<br>-FSBS 51-70 immediately eat take injection just before eating reduce insulin by 2 units.<br>-FSBS 71-150 take prescribed dose of insulin<br>-If unusually vigorous or eating less than usual, decrease Humalog insulin by 1 unit.<br>-If unusually inactive, or eating more than usual, increase Humalog insulin by 1 unit.<br><br>Review of Resident #1's physician order dated 9/12/17 revealed Humalog 7 units every day at lunch<br><br>Review of Resident #1's August 2017 electronic Medication Administration Record (EMAR) for 8/22/17 to 8/31/17 revealed.<br>-There was an entry for Humalog insulin per sliding scale scheduled before meals at 7:30am, 11:30am, and 4:30pm.<br>-There was an entry for Humalog insulin 4 units scheduled at 8:00am and 12:00pm. The entry was used to document the location of administration<br>-There was an entry for Humalog insulin 6 units scheduled at 5:30pm. The entry was used to document the location of administration.<br>-There was an entry for Humalog insulin per sliding scale scheduled at 8:00pm dated 8/1/17 to 8/10/17. The entry was discontinued on 8/10/17.<br>-There was an entry for Humalog insulin per sliding scale scheduled at 8:00pm dated 8/11/17 to 8/31/17<br>-The premeal FSBS's ranged from 53 to 464 from 8/22/17 to 8/31/17<br>-The bedtime FSBS's ranged from 45 to 253 for the month of August<br>-The Humalog insulin sliding scale and scheduled | D 358 | 4. Proper use of emergency glucagon kit for diabetics 11.10.17<br><br>Met with Pharmacy to ensure all insulin orders are separated routine vs. sliding scale to reduce any possibility of errors. 11.10.17<br><br>Pharmacy consultant will monitor all orders quarterly when chart review is done.<br><br>Diabetic training will be provided by pharmacy RN twice yearly for all medication technicians. | |

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premeal doses were documented as administered incorrectly for 12 occurrences out of 30 opportunities.
-For example, on 8/22/17 at 7:30am, the FSBS was 376, 13 units were documented administered, 11 units were required.
-On 8/23/17 at 7:30am, the FSBS was 61, 4 units were documented as administered, 2 units were required.
-On 8/27/17 at 7:30am, the FSBS was 54, 0 units were documented as administered, 2 units were required.
-On 8/28/17 at 7:30am, the FSBS was 56, 0 units were documented as administered, 2 units were required.
-On 8/28/17 at 4:30pm, the FSBS was 210, 2 units were documented as administered, 8 units were required.
-On 8/29/17 at 11:30am, the FSBS was 344, 5 units were documented as administered, 9 units were required.
-On 8/31/17 at 7:30am, the FSBS was 53, 4 units were documented as administered, 2 units were required.
-The Humalog insulin sliding scale at 8pm was documented as administered incorrectly for 2 occurrences out of 15 opportunities.
-For example on 8/5/17, the FSBS was 243, 2 units were documented as administered, 1 unit was required.
-On 8/13/17, the FSBS was 200, 1 unit was documented as administered, none required.

Review of Resident #1's September 2017 EMAR revealed:
-There was an entry for Humalog insulin per sliding scale scheduled before meals at 7:30am, 11:30am, and 4:30pm.
-There was an entry for Humalog insulin 4 units scheduled at 8:00am. The entry was used to

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document the location of administration.
-There was an entry for Humalog insulin 4 units scheduled at 12:00pm from 9/1/17 to 9/13/17. The entry was used to document the location of administration.
-There was an entry for Humalog insulin 7 units scheduled at 12:00pm from 9/13/17 to 9/30/17. The entry was used to document the location of administration.
-There was an entry for Humalog insulin 6 units scheduled at 5:30pm. The entry was used to document the location of administration.
-There was an entry for Humalog insulin per sliding scale scheduled at 8:00pm dated 9/1/17 to 9/30/17.
-The premeal FSBS's ranged from 44 to 521 for the month of September.
-The bedtime FSBS's ranged from 67 to 450 for the month of September.
-The Humalog insulin sliding scale and scheduled premeal doses were documented as administered incorrectly for 20 occurrences out of 91 opportunities.
-For example, on 9/3/17 at 7:30am, the FSBS was 65, 0 units were documented administered, 2 units were required.
-On 9/6/17 at 11:30am, the FSBS was 67, 0 units were documented as administered, 2 units were required.
-On 9/7/17 at 7:30am, the FSBS was 58, 0 units were documented as administered, 2 units were required.
-On 9/11/17 at 11:30am, the FSBS was 140, 0 units were documented as administered, 4 units were required.
-On 9/13/17 at 7:30am, the FSBS was 78, 0 units were documented as administered, 4 units were required.
-On 9/17/17 at 5:00pm, the FSBS was 52, 0 units were documented as administered, 4 units were

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required.
-The Humalog insulin sliding scale at 8pm was documented as administered incorrectly for 2 occurrences out of 24 opportunities.
-On 9/12/17, the FSBS was 409, 0 units was documented as administered, MD order was required.
-On 9/17/17, the FSBS was 450, 5 units were documented as administered, MD order was required.

Review of Resident #1's October 2017 EMAR revealed:
-There was an entry for Humalog insulin 4 units scheduled at 8:00am. The entry was used to document the scheduled premeal insulin and the sliding scale insulin.
-There was an entry for Humalog insulin 7 units scheduled at 12:00pm. The entry was used to document the scheduled premeal insulin and the sliding scale insulin.
-There was an entry for Humalog insulin 6 units scheduled at 5:30pm. The entry was used to document the scheduled premeal insulin and the sliding scale insulin.
-There was an entry for Humalog insulin per sliding scale scheduled at 8:00pm dated 10/1/17 to 10/31/17.
-The premeal FSBS's ranged from 34 to 556 for the month of October.
-The bedtime FSBS's ranged from 54 to 489 for the month of October.
-The Humalog insulin sliding scale and scheduled premeal doses were documented as administered incorrectly for 10 occurrences out of 92 opportunities.
-For example, on 10/23/17 at 8:00am, the FSBS was 34, 4 units were documented administered, 0 units were required.
-On 10/9/17 at 12:00pm, the FSBS was 80, 0

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units were documented as administered, 7 units were required.
-On 10/21/17 at 12:00pm, the FSBS was 70, 7 units were documented as administered, 5 units were required.
-On 10/25/17 at 12:00pm, the FSBS was 85, 0 units were documented as administered, 7 units were required.
-On 10/24/17 at 5:00pm, the FSBS was 83, 0 units were documented as administered, 6 units were required.
-On 10/29/17 at 5:00pm, the FSBS was 69, 6 units were documented as administered, 4 units were required.
-The Humalog insulin sliding scale at 8pm was documented as administered incorrectly for 2 occurrences out of 22 opportunities.
-On 10/19/17, the FSBS was 444, 7 units were documented as administered, MD order was required, no documentation order obtained.
-On 10/25/17, the FSBS was 489, 7 units were documented as administered, MD order was required, no documentation order obtained.

Interview with the Resident Care Coordinator on 11/2/17 at 11:55am revealed:
-"On the sliding scale insulin, the software pops up and tells you what dose to give" after the medication aide enters the FSBS result.
-The pharmacy entered the sliding scale and "you can only see the scale during the med pass."
-The parameters ordered by the physician about how to treat FSBS less than 50, and 51-150 would have to be entered by the pharmacy as a "extra instructions" note or the medication aide would have to pull the original order to see the parameter orders.
-For a FSBS greater than 400, the medication aide should have just "given the highest sliding scale amount and scheduled amount of insulin."

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-Resident #1 had no incidents of hospitalization, due to high or low blood sugars from May 2017 to current.
-To ensure the information in the EMAR was accurate the medication aide "would have to compare the orders with the med pass notes on the screens."
-"If the pharmacy doesn't put all the instruction in then the medication aide would not know" what the complete order was without going to the resident's record and looking at the original order.

Interview with one medication aide on 11/2/17 at 12:10pm revealed:
-She worked as a float medication aide and had often administered Resident #1's medications.
-Resident #1 received a scheduled premeal dose of insulin and a sliding scale dose of insulin before meals.
-In the EMAR they used to document medication administrations the premeal and sliding scale were under one pop up administration time for Resident #1.
-The scheduled dose would automatically come up, but one had to enter the FSBS result and the EMAR calculated the correct dose of sliding scale based on the FSBS.
-The medication aide would then have to add the two values together and enter that in a box indicating the amount of insulin administered.
-The sliding scale used by the EMAR to calculate the dose to administer was not visible to the medication aide.
-"We used to have her [Endocrinologist's orders] hanging in the med room where we could look at it" to remind staff of what amount of insulin to administer when the residents FSBS was less than 50, 51-70, or 71-150.
-"There was nothing that popped up on the EMAR that instructed us what to do" with the special

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parameter orders from the physician.

Interview with a second medication aide on 11/2/17 at 12:30pm revealed:
-"Pharmacy didn't have the parameters in there we just had to look at the order."
-"We actually had the order hanging in the med room."
-Only the pharmacy could make changes to the EMAR.
-"We added them together because that's how the pharmacy had them in there" referring to totaling the scheduled premeal dose with the required amount of sliding scale insulin required.

Telephone interview with the facility's pharmacy on 11/2/17 at 2:15pm revealed:
-"When we originally worked on the sliding scale insulin, the facility requested it be attached to the scheduled order."
-"Now we are separating it out so you have to document each individual insulin."
-"If the blood glucose was greater than 400 it just says contact MD" referring to what a medication aide would see in the EMAR software after entering a FSBS result greater than 400.
-The medication aide would then need to contact the physician and report the elevated FSBS and get a verbal order to know how much insulin to administer.

Attempted telephone interview with Resident #1's physician on 11/2/17 at 1:00pm was unsuccessful by exit.

Refer to the interview with Resident #1 on 11/1/17 at 9:10am.

B. Review of Resident #1's signed physician order sheets dated 8/22/17 and 9/6/17 revealed

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an order for Glucagon (a hormone used to treat severe low blood sugar) 1mg emergency kit use as directed for unresponsive hypoglycemia.

Review of Resident #1's current FL2 dated 10/19/17 revealed an order for Glucagon 1mg emergency kit use as directed for unresponsive hypoglycemia.

Observation of Resident #1's medications on hand on 11/1/17 at 3:00pm revealed there was no Glucagon 1mg emergency kit available.

Interview with one medication aide on 11/1/17 at 3:10pm revealed:
-"The Glucagon emergency kit was last filled 5/27/16."
-"They used it and didn't reorder it."
-"I will reorder it and it will come in today at 8 or 9pm."

Review of Resident #1's August, September, and October 2017 EMARs revealed:
-An entry for Glucagon 1mg emergency kit.
-There were no documented administrations of the medication during August, September, or October 2017.
-In August, Resident #1 had 5 documented FSBS less than 50 including on 8/4/17 at 12:00pm FSBS 45, 8/8/17 at 8:00pm FSBS 50, 8/5/17 at 8:00am FSBS 45, 8/14/17 at 7:30am FSBS 43, and 8/21/17 at 7:30am FSBS 40.
-In September and October 2017, there were no documented FSBS's less than 50.

Interview with the same medication aide on 11/2/17 at 12:10pm revealed:
-"We have the Glucagon injection now."
-She had received training on how to use it.
-"I know how to use it, we just haven't had it."

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-"If it's below 50, we give glucose gel. It will usually bring it up."
-"If it doesn't bring it up enough, we give her some milk and peanut butter sandwich.

Interview with a second medication aide on 11/2/17 at 12:30pm revealed:
-"All I know about is the glucose gel."
-"It's pretty easy to get her sugar up."
-"A lot of times we can give her a little orange juice and it will come backup."

Telephone interview with the facility's pharmacy on 11/2/17 at 2:15pm revealed:
-The Glucagon 1mg emergency kit was last filled for Resident #1 on 11/1/17.
-"The original date on the current order was 5/23/17, but I have an order all the way back to June of 2014."
-Before 11/1/17, the pharmacy had last filled it on 6/30/14.
-"We would then have refilled on an as needed basis."

Attempted telephone interview with Resident #1's physician on 11/2/17 at 1:00pm was unsuccessful by exit.

Refer to the interview with Resident #1 on 11/1/17 at 9:10am.

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Interview with Resident #1 on 11/1/17 at 9:10am revealed:
-She received fingerstick blood sugar checks four times a day.
-She was an insulin dependent diabetic.
-She had no issues with the timing of when staff administered her medications or what medications she was given.

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-She never ran out of medications.
-She was able to see her physician anytime she had medical concerns and received frequent visits with the physician who managed her diabetes.

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The facility failed to administer sliding scale insulin and follow parameter orders as ordered for 1 of 2 sampled residents (Resident #1) resulting in the resident experiencing numerous high and low blood sugars. The facility's failure to administer medications and follow medication parameters as ordered and not having Glucagon on hand to use in case of an unresponsive hypoglycemic event was detrimental to the health and safety of Resident #1 which constitutes a Type B Violation.

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A Plan of Protection was received from the facility on 11/1/17 as follows:
-Contacted facility pharmacy to correct insulin orders in the computer.
-Contacted facility pharmacy to deliver Glucagon emergency kit and the kit should arrive within an hour.
-Placed calculator on the medication cart to assure units are being calculated correctly.
-Placed a note on the medication cart to make sure all staff are doing insulin order correct and calculating correctly.
-Educated staff to always call physician with any concerns regarding insulin orders.
-Educated staff to always have Glucagon emergency kit in the medication cart.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 17, 2017.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL044041 | A. BUILDING: _____ B. WING _____ | 11/02/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPICEWOOD COTTAGES WILLOWS | 65 LOVING WAY CLYDE, NC 28721 |

| (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 |
|---|---|---|---|---|
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights | D912 | | |

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 to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration.

The findings are:

Based on observations, interviews, and record reviews, the facility failed to ensure Humalog was administered as ordered for 1 of 2 sampled residents (Resident #1) who had orders for insulin and Glucagon was available for administration. [Refer to Tag 358, 10A NCAC .1004(a) Medication Administration (Type B Violation).]