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
	HAL033006	A. BUILDING: _____ B. WING _____	R-C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(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 Edgecombe County Department of Social Services conducted a follow-up survey and complaint investigation on October 18, 2023. The complaint investigation was initiated by the Edgecombe County Department of Social Services on October 5, 2023.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
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: FOLLOW-UP TO TYPE A2 VIOLATION. The Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents (#1) observed during the medication pass including errors with insulin; and for 1 of 5 sampled residents (#1) for record review including errors with insulin. The findings are: 1. The medication error rate was 6% as evidenced by 2 errors out of 30 opportunities	D 358	The Bridges of Hendricks Creek shall ensure that the preparation and administration of medications and treatments by staff are according to Providers' orders, which are maintained in the Resident's record, the facility's policies and procedures, and the rules in Section .1004(a). Area Clinical Director (ACD) in-serviced Med Techs on the 6 Rights of Medication Administration, the importance of clarifying orders when needed, the importance of accurate documentation, diabetes management, and how to accurately administer insulin. 10/23/23 Med Techs will complete MAR to cart audits per facility schedule to ensure availability and accuracy of medications and supplies on medication carts. The audits will be reviewed by the RCC upon completion for compliance, and to ensure accurate and adequate medications are on hand at all times. 12/2/23 Resident Care Coordinator (RCC) will complete cart audits weekly for 12/2/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joshua Lanier — TITLE: Executive Director — (X6) DATE: 11/17/2023

Reviewed and Acknowledged PHR 11/17/23

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D 358	Continued From page 1 during the 8:00am medication pass on 10/18/23. Review of Resident #1's current FL-2 dated 08/24/23 revealed diagnoses included muscle weakness and acquired absence of left leg below the knee. a. Review of Resident #1's current FL-2 dated 08/24/23 revealed: -There was an order for fingerstick blood sugar check (FSBS) before meals and at bedtime. -There was an order for Novolog (a short-acting insulin used to treat high blood sugar) inject 9 units 3 times daily with meals if FSBS over 150. Observation of the 8:00am medication pass on 10/18/23 revealed: -The medication aide (MA) checked Resident #1's FSBS. -Resident #1's FSBS was 169 at 8:30am. -The MA placed a needle on Resident #1's Novolog pen. -The MA used her pen to tap the side of the Novolog pen. -The MA dialed the Novolog pen to 9. -The MA swabbed Resident #1's left upper abdomen with an alcohol wipe. -The MA administered 9 units of Novolog to Resident #1 at 8:38am. -The MA did not prime Resident #1's Novolog with 2 units prior to administering the medication. Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm, and 8:00pm. -FSBS was documented as 169 at 7:30am on 10/18/23.	D 358	overall QA of the medication carts to ensure the cart is stocked with appropriate and accurate medications and clinical supplies. Completed audits will be reviewed with the Executive Director (ED), and any concerns will be addressed promptly. RCC will ensure that all new, updated, and/or changed orders are faxed to the pharmacy and verified to allow for updates of the eMAR. 12/2/23 ACD will perform random med pass observations during site visits at a minimum of 3 observations per month to ensure Med Aides are performing medication admin procedures appropriately. Any noted concerns of improper med administration will be discussed with the ED/RCC for appropriate follow-up, including additional training needed. 12/2/23 RCC will complete a minimum of 2 chart audits weekly to ensure that all orders have been processed properly to allow for accurate med administration. 12/2/23 RCC will pull Medication Compliance Reports daily to ensure medications are administered per MD orders. Reports will be reviewed with the ED during management meeting daily for compliance. Any noted areas of concern will have follow-up as appropriate, including MD notifications, clarifications, and any interventions needed. 12/2/23	

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D 358	Continued From page 2 -There was an entry for Novolog inject 9 units 3 times daily with meals if FSBS is over 150 scheduled for administration at 8:00am, 12:00pm, and 5:00pm. -Novolog 9 units was documented as administered at 8:00am on 10/18/23. Interview with the MA on 10/18/23 at 12:17pm revealed: -When she administered insulin to residents via insulin pen, she was supposed to "waste" 2 units of insulin before administering the insulin to a resident. -The reason she was supposed to waste 2 units of insulin was to remove any bubbles that may be in the pen. -She used her pen to tap on the side of Resident #1's Novolog pen to remove any bubbles before administering it to him. -She did not waste 2 units of Resident #1's Novolog before administering it to him. Interview with the Administrator's assistant on 10/18/23 at 12:24pm revealed: -The facility's Resident Care Coordinator (RCC) was out on medical leave. -She was the Administrator at another facility but was at this facility today to assist the Administrator in the RCC's absence. -A MA should prime an insulin pen with 2 units of insulin prior to administering it to a resident. -It was important to prime the insulin pen with 2 units of insulin prior to administration to remove any air from the needle. Interview with the Administrator on 10/18/23 at 12:31am revealed he expected MAs to follow proper technique when administering insulin to residents.	D 358		

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Telephone interview with Resident #1's primary care provider (PCP) on 10/18/23 at 3:54pm revealed:
-She expected MAs to prime Resident #1's insulin pen with 2 units of insulin prior to administering it to the resident.
-Not priming Resident #1's insulin pen with 2 units of insulin prior to administration could cause the resident to receive an incorrect dosage of insulin which could cause him to have high FSBSs.

b. Review of Resident #1's current FL-2 dated 08/24 23 revealed there was an order for Lantus (a long-acting insulin used to treat high blood sugars) 8 units every morning.

Review of Resident #1's progress note dated 09/14/23 revealed there was an order to increase Lantus 8 units in the morning to 10 units.

Review of Resident #1's physician order sheet dated 10/02/23 revealed there was an order to discontinue the order for Lantus increase from 8 units to 10 units.

Observation of the 8:00am medication pass on 10/18/23 revealed:
-The medication aide (MA) placed a needle on Resident #1's Lantus pen.
-The MA used her pen to tap the side of the Lantus pen.
-The MA dialed the Lantus pen to 8.
-The MA swabbed Resident #1's right upper abdomen with an alcohol wipe.
-The MA administered 8 units of Lantus to Resident #1 at 8:38am.
-The MA did not prime Resident #1's Lantus with 2 units prior to administering the medication.

Review of Resident #1's October 2023 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Lantus inject 8 units every morning scheduled for administration at 8:00am.
-Lantus 8 units was documented as administered at 8:00am on 10/18/23.

Interview with the MA on 10/18/23 at 12:17pm revealed:
-When she administered insulin to residents via insulin pen, she was supposed to "waste" 2 units of insulin before administering the insulin to a resident.
-The reason she was supposed to waste 2 units of insulin was to remove any bubbles that may be in the pen.
-She used her pen to tap on the side of Resident #1's Lantus pen to remove any bubbles before administering it to him.
-She did not waste 2 units of Resident #1's Lantus before administering it to him.

Interview with the Administrator's assistant on 10/18/23 at 12:24pm revealed:
-The facility's Resident Care Coordinator (RCC) was out on medical leave.
-She was the Administrator at another facility but was at this facility today to assist the Administrator in the RCC's absence.
-A MA should prime an insulin pen with 2 units of insulin prior to administering it to a resident.
-It was important to prime the insulin pen with 2 units of insulin prior to administration to remove any air from the needle.

Interview with the Administrator on 10/18/23 at 12:31am revealed he expected MAs to follow proper technique when administering insulin to residents.

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D 358	Continued From page 5 Telephone interview with Resident #1's primary care provider (PCP) on 10/18/23 at 3:54pm revealed: -She expected MAs to prime Resident #1's insulin pen with 2 units of insulin prior to administering it to the resident. -Not priming Resident #1's insulin pen with 2 units of insulin prior to administration could cause the resident to receive an incorrect dosage of insulin which could cause him to have high FSBSs. 2. Review of Resident #1's current FL-2 dated 08/24/23 revealed: -Diagnoses included muscle weakness and acquired absence of left leg below the knee. -There was an order for Lantus (a long-acting insulin used to treat high blood sugars) 8 units every morning. Review of Resident #1's progress note dated 09/14/23 revealed there was an order to increase Lantus 8 units in the morning to Lantus 10 units in the morning. Review of Resident #1's progress note dated 10/02/23 revealed medications were reconciled on the electronic medication administration record (eMAR) and the resident had an order dated 09/14/23 to increase Lantus 8 units to Lantus 10 units but the eMAR still reflected 8 units. Review of Resident #1's physician order sheet dated 10/02/23 revealed there was an order to discontinue the order for Lantus increase from 8 units to 10 units. Review of Resident #1's September 2023 electronic medication administration record	D 358		

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D 358	Continued From page 6 (eMAR) revealed: -There was an entry for Lantus inject 8 units every morning scheduled for administration at 8:00am. -Lantus 8 units was documented as administered at 8:00am on 09/14/23 to 09/30/23 except on 09/21/23 and 09/22/23 where it was documented the resident was at the hospital. -There was no entry for Lantus 10 units every morning. Review of Resident #1's October 2023 eMAR revealed: -There was an entry for Lantus inject 8 units every morning scheduled for administration at 8:00am. -Lantus 8 units was documented as administered at 8:00am on 10/01/23 and 10/02/23. -There was no entry for Lantus 10 units every morning. Interview with Resident #1 on 10/18/23 at 2:52pm revealed: -He received 8 units of Lantus every morning. -He was not aware of his morning Lantus every being increased to 10 units. Interview with a medication aide (MA) on 10/18/23 at 12:17pm revealed: -It was the Resident Care Coordinator's (RCC) responsibility to fax new medication order to the facility's contracted pharmacy. -Sometimes the RCC would give the medication orders to a MA and the MA would fax the orders to the pharmacy. Interview with the Administrator's assistant on 10/18/23 at 12:24pm revealed: -The facility's Resident Care Coordinator (RCC) was out on medical leave.	D 358		

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-She was the Administrator at another facility but was at this facility today to assist the Administrator in the RCC's absence.
-The facility used an order processing system for all orders received for residents.
-New orders were placed in a folder to be reviewed by the RCC.
-The RCC then faxed any new medication orders to the facility's contracted pharmacy.
-The pharmacy profiled medications and placed them on the resident's eMARs.
-Medication orders that were entered on the eMAR by the pharmacy were then verified and approved by the RCC.
-The RCC was expected to fax Resident #1's Lantus order to the pharmacy as soon as it was received so it could be placed on the resident's eMAR.
-It was important to fax Resident #1's new Lantus order to the pharmacy as soon as it was received so the resident would receive the correct dosage of insulin so he would not have issues with any increased blood sugars.

Interview with the Administrator on 10/18/23 at 12:31pm revealed:
-The RCC performed chart audits on 2 resident files each week.
-When the RCC performed chart audits she checked the chart to make sure all orders had been processed and were being followed.
-He expected the RCC to send any new medication orders to the facility's contracted pharmacy as soon as they were received.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/18/23 at 12:50pm revealed:
-When the pharmacy received orders from the facility, they entered them on resident's eMARs

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D 358	Continued From page 8 and the facility then approved the orders. -The current order on file for Resident #1's morning dosage of Lantus was 8 units. -The order date for the 8 units of Lantus was 07/10/23. -She did not see an order in their system for Resident #1's morning dosage of Lantus to be increased to 10 units. Telephone interview with Resident #1's primary care provider (PCP) on 10/18/23 at 3:54pm revealed: -She ordered for Resident #1's morning Lantus to be increased from 8 units to 10 units because his blood sugars had been running higher than usual. -When she noticed that Resident #1's Lantus had not been increased to 10 units as ordered she ordered for his Lantus to be decreased back down to 8 units. -She ordered for Resident #1's Lantus to be decreased to 8 units because his hemoglobin A1C had decreased (Hemoglobin A1C is a laboratory test used to measure blood sugar control over a 3-month period). -She expected the facility to increase Resident #1's Lantus to 10 units as ordered on 09/14/23. -Not increasing Resident #1's Lantus to 10 units as ordered could have caused his blood sugars to run high which could cause adverse effects on his kidneys or eyes and put him at increased risk for infection.	D 358		