

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL077011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2015
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NAME OF PROVIDER OR SUPPLIER HERMITAGE RET CNT OF ROCKINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 139 MALLARD LANE ROCKINGHAM, NC 28379
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on September 30, 2015 and October 01, 2015.	D 000		
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure physician notification for 1 of 7 sampled residents (Resident #6) for refusal to wear physician ordered thromboembolism-deterrent (TED) hose.</p> <p>The findings are:</p> <p>Review of Resident #6's current FL2 dated 02/26/15 revealed: - Diagnoses included Alzheimer's Dementia, hyperlipidemia and osteoporosis. - A physician's order for "compression hose to wear when ambulatory".</p> <p>Observation of Resident #6 on 09/30/15 at 10:00 am revealed: - She was walking around in her room at the facility. - There was bilateral lower extremity edema. - The resident was not wearing TED hose.</p> <p>Observation on 10/01/15 at 10:43 am of Resident #6 revealed:</p>	D 273		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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D 273	<p>Continued From page 1</p> <ul style="list-style-type: none"> - She was in the Special Care Unit of the facility. - There was bilateral lower extremity edema. - She was not wearing TED hose. <p>Further review of Resident #6's record revealed:</p> <ul style="list-style-type: none"> - A signed prescribing practitioner's order dated 07/23/15 "TED hose, Pt is to wear compression stockings daily. Pt is non-compliant with keeping stockings on." - A signed prescribing practitioner's order dated 08/24/15, "TED hose on in am and remove at bedtime". <p>Interview on 10/01/15 at 10:45 am am with the Special Care Unit Coordinator (SCUC) revealed:</p> <ul style="list-style-type: none"> - Resident #6 disliked the TED hose and usually refused to wear them. - Resident #6 was noncompliant with wearing her TED hose and won't keep them on. - She tried to have the order for TED hose discontinued in July 2015, because Resident #6 would take them off, hide them or throw them away. - "I don't even know if she has a pair of TED hose at this time". <p>Review of Resident #6's July 2015 Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> - An entry for "JOBST knee. Apply on legs in the morning and remove at bedtime." - The entry was initialed by staff twice each day, indicating TED hose were applied every morning and removed each evening. <p>Review of the August MAR 2015 revealed:</p> <ul style="list-style-type: none"> - An entry for TED hose to be applied every morning and removed every evening. - Each day was marked with staff initials with a circle around them, twice daily, indicating the TED hose had not been applied or removed. 	D 273		

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D 273	<p>Continued From page 2</p> <p>Review of the September 2015 MAR revealed:</p> <ul style="list-style-type: none"> - The entry for TED hose to be applied every morning and removed every evening was marked with circled staff initials, twice daily, indicating the hose had not been applied or removed. <p>Interview with a Personal Care Aide (PCA) on 10/01/15 at 11:50 am revealed:</p> <ul style="list-style-type: none"> - She did not know Resident #6 had an order for TED hose. - She was unaware if TED hose were available for Resident #6. <p>Interview on 10/01/15 at 11:55 am with a PCA revealed:</p> <ul style="list-style-type: none"> - First shift applied the TED hose on Resident #6. - Third shift removed the TED hose. - Resident #6 was noncompliant with TED hose use; she usually would take them off herself. - She did not think there were any TED hose available for Resident #6. <p>Interview with Resident #6's family member revealed:</p> <ul style="list-style-type: none"> - She had purchased TED hose "a while back" for the facility to use for Resident #6. - Resident #6 did not like to wear the TED hose, and would often take them off and hide them or throw them away, which was why she had to purchase the TED hose. <p>Interview with the SCUC on 10/01/15 at 11:30 am revealed:</p> <ul style="list-style-type: none"> - 07/23/15 was the last time she attempted to communicate with the prescribing practitioner concerning Resident #6 being noncompliant with the TED hose use. (Copy of a facility fax to the prescriber was observed in the record.) - She had no additional documentation of 	D 273		

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D 273	Continued From page 3 communication with the prescribing practitioner concerning the TED hose with Resident #6. Attempted interview with Resident #6's primary care physician on 09/30/15 at 5:35 pm was unsuccessful. Based on observation and record review, it was determined that Resident #6 was not interviewable.	D 273		
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 observation, interview, and record review, the facility failed to assure documentation of implementation of physician's orders for 2 of 3 sampled residents (Resident #9 and #12) related to checking fingerstick blood sugar (FSBS) and administering sliding scale insulin (SSI). The findings are: Based on information provided by the facility, it was revealed there were 29 residents in the	D 276		

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D 276	<p>Continued From page 4</p> <p>facility receiving fingerstick blood sugar checks (FSBS) with 17 of these residents located on the assisted living unit and 12 residents located in the Special Care Unit.</p> <p>Observation on 9/30/15 at 4:20 pm revealed:</p> <ul style="list-style-type: none"> - The facility had a medication treatment cart for the Assisted Living Unit used to store the 17 residents' diabetic supplies. - The treatment cart had 3 rows of individual pull-out plastic trays (approximately 4 inches deep) and 17 trays labeled with a resident's name. (The names matched residents identified for receiving FSBS). <p>Observation on 10/01/15 at 9:40 am revealed:</p> <ul style="list-style-type: none"> - The facility had a medication treatment cart for the Special Care Unit used to store the 12 residents' diabetic supplies. - The treatment cart had 2 rows of individual pull-out plastic trays (approximately 4 inches deep) and 12 trays labeled with a resident's name. (The names matched residents identified for receiving FSBS). <p>A. Review of Resident #12's current FL-2 dated 7/08/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included Alzheimer's disease, dementia, and diabetes type II. - The resident's recommended level of care was Special Care Unit. - An order for Novolog Mix 70/30 insulin inject 10 units at 6:30 am. (Novolog Mix is a combination of long-acting and short acting insulin analogs used to treat elevated blood sugar in diabetics.) - An order to check fingerstick blood sugar (FSBS) checks before meals and at bedtime. - An order for Humalog Insulin (a fast acting insulin analog) used as sliding scale before meals and at bedtime. 	D 276		

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D 276	<p>Continued From page 5</p> <p>- Sliding Scale Insulin (SSI) parameters ordered for administering Humalog Insulin were listed for FSBS values as follows: 150-199=3 units, 200-249=6 units, 250-299=9 units, 300-349=12 units, 350-399=15 units, greater than 400= notify physician.</p> <p>Review of Resident #12's Resident Register revealed an admission date of 7/13/2012.</p> <p>Observation on 09/30/15 during the initial tour revealed Resident #12 resided in the Special Care Unit of the facility.</p> <p>Observation of medication administration in the Special Care Unit on 10/01/15 at 8:40 am revealed Resident #12 received 7 oral medications.</p> <p>Interview on 10/01/15 at 8:40 am with the dayshift Medication Aide for Special Care Unit administering Resident #12's medications revealed Resident #12 had already been administered her insulin earlier in the day.</p> <p>Review of the history of the glucometer labeled with Resident #12's name revealed:</p> <ul style="list-style-type: none"> - Time and date were not set correctly in the glucometer. (On 10/01/15 at 10:45 am the glucometer displayed 9/16/15 at 10:54 am). - FSBS values (adjusted for date and time) recorded in the history of the glucometer were inconsistent with FSBS values documented on Resident #12's September 2015 Medication Administration Record (MAR). - From 9/16/15 to 9/30/15 a total of 43 FSBS values were recorded in the glucometer's history. - For the 15 day period a total of 60 FSBS values should have been recorded in the glucometer's history based on 4 FSBS ordered daily.) 	D 276		

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D 276	<p>Continued From page 6</p> <p>Review of Resident #12's September MAR revealed:</p> <ul style="list-style-type: none"> - FSBS and SSI were scheduled at 6:30 am, 10:30 am, 4:30 pm and 8:00 pm. - FSBS values were documented 60 times from 9/16/15 to 9/30/15. - SSI was administered 12 times from 9/16/15 to 9/30/15 according to SSI parameters based on FSBS values documented on the resident's MAR, but FSBS values were not documented in the resident's glucometer history. - Seven of the SSI administrations occurred at the 4:30 pm scheduled FSBS. - The remainder of times were spread throughout the additional scheduled times. <p>FSBS values documented on Resident #12's September MAR for 4:30 pm from 9/16/15 to 9/30/15 but not recorded in the glucometer's history and SSI documented administered were as follows:</p> <ul style="list-style-type: none"> - On 9/21 FSBS on MAR=250, SSI= 9 units and no FSBS value recorded in glucometer's history. - On 9/23 FSBS on MAR=243, SSI= 6 units and no FSBS value recorded in glucometer's history. - On 9/24 FSBS on MAR=178, SSI= 3 units and no FSBS value recorded in glucometer's history. - On 9/27 FSBS on MAR=167, SSI= 3 units and no FSBS value recorded in glucometer's history. - On 9/28 FSBS on MAR=173 SSI= 3 units and 163 FSBS value recorded in glucometer's history. - On 9/29 FSBS on MAR=250, SSI= 3 units and no FSBS value recorded in glucometer's history. - On 9/30 FSBS on MAR=189, SSI= 3 units and no FSBS value recorded in glucometer's history. <p>Interview on 10/01/15 at 3:00 pm with a morning shift Medication Aide in the Special Care Unit revealed:</p>	D 276		

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D 276	<p>Continued From page 7</p> <ul style="list-style-type: none"> - The Special Care Unit Coordinator (SCUC) was responsible for ordering and maintaining diabetic supplies for the residents in the special care unit and the assisted living unit. - The MA stated the facility policy was an assigned glucometer for each resident and to use only the assigned glucometer to obtain FSBS values. - The MA stated She routinely worked dayshift from 6:00 am to 2:00 pm. - The MA stated She had never shared a glucometer. - The MA stated She administered SSI according to the FSBS value she obtained from fingersticks. <p>Interview on 10/01/15 at 5:40 pm with an evening shift MA in the Special Care Unit revealed:</p> <ul style="list-style-type: none"> - The evening shift MA was scheduled 2:00 pm to 10:00 pm. - She had worked at the facility for 2 years. - The facility policy was one glucometer assigned to each resident; the assigned glucometer was supposed to be used to obtain FSBS for the assigned resident. - She would be responsible for taking resident's FSBS scheduled for 4:30 pm and 8:00 pm. - The SSI insulin she administered to residents would be based on the residents' ordered sliding scale and the FSBS value documented on the MAR. - The MA stated she did not know why FSBS values she documented for Resident #13 were not in the glucometer's memory history. <p>Interview on 10/01/15 at 5:50 pm with the SCUC revealed:</p> <ul style="list-style-type: none"> - The SCUC could not explain why Resident #12 had FSBS values recorded on the MAR that were not in the resident's glucometer. - The SCUC did not have a system in place 	D 276		

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D 276	<p>Continued From page 8</p> <p>currently to monitor FSBS values in glucometers' history compared to FSBS values documented on the MARS.</p> <ul style="list-style-type: none"> - She randomly audited 1 to 3 records each week to assure the MAs were completing the MAR documentation. <p>Based on record review and observation on 10/01/15, Resident #12 was determined unable to provide reliable information.</p> <p>Refer to interview on 10/01/15 at 5:00 pm with the Administrator.</p> <p>Refer to interview on 10/01/15 at 5:20 pm with the Resident Service Director (RSD).</p> <p>B. Review of Resident #9's current FL-2 dated 7/27/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included peripheral vascular disease, paralysis, and late effect of cerebrovascular disease. - The resident's recommended level of care was assisted living. <p>Review of the Resident Register revealed Resident #9 was admitted to the facility on 7/29/15.</p> <p>Review of Resident #9's record revealed:</p> <ul style="list-style-type: none"> - A facility fax from Resident #9's physician for adding diagnoses of history of cerebrovascular accident and diabetic. - A physician's order dated 8/05/15 for Fingerstick Blood Sugar (FSBS) checks 3 times a day and Regular Humulin Insulin (a rapid acting insulin for lowering elevated blood sugar in diabetics) Sliding Scale Insulin (SSI) per FSBS scale as follows: 81-180=0 units, 181-270=2 units, 271-350=4 units, 351-450=8 units, FSBS greater 	D 276		

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D 276	<p>Continued From page 9</p> <p>than 450 20 units and call Physician.</p> <p>Review of the history of the glucometer labeled with Resident #9's name revealed:</p> <ul style="list-style-type: none"> - Time and date were set correctly in the glucometer.. - From 9/18/15 to 9/30/15 a total of 43 FSBS values were recorded in the glucometer's history, including extra values later determined to be documented rechecks for low values for FSBS on 9/26/15 9/23/15 and 9/22/15. - On 9/21/15 at 7:00 am, no FSBS value was recorded in the glucometer's history. - On 9/18/15 at 11:00 am, no FSBS value was recorded in the glucometer's history. - On 9/17/15 at 7:00 am, 11:00 am, and 4:00 pm, no FSBS value was recorded in the glucometer's history. - On 9/16/15 at 7:00 am, 11:00 am, and 4:00 pm, no FSBS value was recorded in the glucometer's history. - On 9/15/15 at 4:00 pm, no FSBS value was recorded in the glucometer's history. <p>Review of Resident #9's September MAR revealed:</p> <ul style="list-style-type: none"> - FSBS values recorded in the history of the glucometer were inconsistent with FSBS values documented on Resident #9's September 2015 Medication Administration Record (MAR). - FSBS and SSI were scheduled at 7:00 am, 11:00 am, and 4:00 pm. - SSI was administered 4 times from 9/15/15 to 9/30/15 according to SSI parameters based on FSBS values documented on the resident's MAR but, FSBS values were not documented in the resident's glucometer's history. <p>FSBS values documented on Resident #9's September MAR from 9/16/15 to 9/30/15, but not</p>	D 276		

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D 276	<p>Continued From page 10</p> <p>recorded in the glucometer's history and SSI documented administered were as follows:</p> <ul style="list-style-type: none"> - On 9/21 at 7:00 am, FSBS on MAR=210, SSI= 2 units and no FSBS value was recorded in glucometer's history, - On 9/17 at 11:00 am, FSBS on MAR=182, SSI=2 units and no FSBS value was recorded in glucometer's history, - On 9/17 at 4:00 pm FSBS on MAR=208, SSI= 2 units and no FSBS value was recorded in glucometer's history, - On 9/15 at 4:00 pm FSBS on MAR=202, SSI= 2 units and no FSBS value was recorded in glucometer's history. <p>Interview on 10/01/15 at 5:50 pm with the SCUC revealed:</p> <ul style="list-style-type: none"> - She was responsible for ordering diabetic supplies for the residents in the special care unit and assisted living unit. - The SCUC was not aware of any system in place currently to monitor FSBS values in glucometers' history compared to FSBS values documented on the residents' MARs. <p>Interview on 10/01/15 at 6:12 pm with Resident #9 revealed:</p> <ul style="list-style-type: none"> - Medication Aides did FSBS checks on him every day, at least 3 to 4 times a day. - He did not recall when staff had missed checking his FSBS. - He was not sure if staff always used a glucometer labeled with his name. - He did not always pay attention to the type of glucometer used but the glucometer looked the same. <p>Refer to interview on 10/01/15 at 5:00 pm with the Administrator.</p>	D 276		

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D 276	<p>Continued From page 11</p> <p>Refer to interview on 10/01/15 at 5:20 pm with the Resident Service Director (RSD).</p> <p>Interview on 10/01/15 at 5:00 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> - She was aware of possible values documented on the MAR but not in the residents' glucometers' histories. - She had suspended a Medication Aide, within the last 3 weeks, due to review of the facility's video surveillance tapes that supported the fact that the staff member was observed obtaining less FSBS than were documented on at least one shift. - The Administrator stated some residents had glucometers replaced within the last few months, but staff should be using the assigned glucometer for obtaining FSBS values. - The Administrator stated it appeared that either the MAs used a different glucometer or falsely documented the FSBS values. <p>Interview on 10/01/15 at 5:20 pm with the Resident Service Director (RSD) revealed:</p> <ul style="list-style-type: none"> - She was responsible for health care for residents in both the assisted living unit and the special care unit. - The SCUC was in charge of ordering diabetic supplies for both units. - The RSD was not aware of a current system in place to monitor FSBS documentation compared to the residents' MAR to assure residents received treatments and medications as ordered. - The RSD stated MAs had been trained to use only assigned glucometers to check residents' FSBS and to report any instances when a FSBS could not be obtained to the RSD or SCUC. - She was aware of a suspension of a MA, within the last 2 weeks, while the facility investigated potential inappropriate documentation of FSBS. 	D 276		

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D 276	Continued From page 12 The facility provided a Plan of Protection on 10/01/15 as follows: -Immediately review records to ensure all Doctor orders are being followed and documented. - Immediately in-service with staff on FSBS and ensuring correct insulin is given for that reading. - Weekly checks by the Resident Coordinator of documentation and direct observation by Administrator to ensure blood sugar is being checked with correct meter, right documentation and correct follow through. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 15, 2015.	D 276		
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 observation, interview, and record review, the facility failed to administer medications as ordered by a licensed practitioner for 1 of 6 residents (Resident #12) observed during medication administration on 9/30/15 and 10/01/15. The findings are:	D 358		

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D 358	<p>Continued From page 13</p> <p>Review of Resident #12's current FL-2 dated 7/08/15 revealed diagnoses including Alzheimer's disease, dementia, and diabetes type II.</p> <p>Observation on 10/01/15 at 8:40 am of medication administration by a dayshift Medication Aide (MA) for the Special Care Unit revealed:</p> <ul style="list-style-type: none"> - The MA prepared 7 oral medications (5 solid dose medications and 2 liquid medications) and administered the medications to Resident #12. - Invokana 300 mg (used to treat elevated blood sugar in diabetics) was included in the 5 solid dose medications. <p>Review of Resident #12's record revealed:</p> <ul style="list-style-type: none"> - The FL-2 dated 7/08/15 had an order for Januvia 100 mg (used to treat elevated blood sugars in diabetics) daily. - A subsequent physician order dated 8/05/15 to discontinue Januvia 100 mg daily. - A physician order dated 8/05/15 prescribing Invokana 300 mg daily. <p>Review of the physician's visit summary dated and electronically signed on 9/02/15 by the facility's contract physician for Resident #12 revealed:</p> <ul style="list-style-type: none"> - Documentation to "DISCONTINUE: Invokana 300mg oral tablet One tablet daily". - Documentation to "PRESCRIBE: Invokana 100 mg oral tablet, Take 1 pill by mouth QAM [every morning] X 1 month (30d). (STOP 300 MG)". <p>Continued review of Resident #12's record revealed a physician's visit summary, dated and signed 9/16/15 by the facility's house physician, ordering Invokana 100 mg oral tablet, Take one by mouth every morning for one month listed</p>	D 358		

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D 358	<p>Continued From page 14</p> <p>under medications.</p> <p>Review of Resident #12's August 2015 Medication Administration Record (MAR) revealed Invokana 300 mg one tablet daily (in the morning) was handwritten on the MAR, scheduled for administration at 8:00 am daily beginning on 8/6/15 and documented for administration daily through 8/31/15.</p> <p>Review of Resident #12's September 2015 and October 2015 Medication Administration Record (MARs) revealed Invokana 300 mg one tablet daily (in the morning), scheduled for administration at 8:00 am daily was preprinted on the MARs and documented for administration daily from 9/01/15 to 10/01/15.</p> <p>Observation on 10/01/15 of Resident #12's medication on hand for administration revealed a partial bingo card of Invokana 300 mg tablets and no Invokana 100 mg tablets were on hand for administration.</p> <p>Interview on 10/01/15 at 9:10 am with the Special Care Unit Coordinator (SCUC) revealed:</p> <ul style="list-style-type: none"> - The contracted House Physician routinely came at the facility every 2 weeks, alternating routine visits to the assisted living and special care for resident appointments. (The physician would work in residents from the opposite unit for acute needs.) - The SCUC was routinely responsible to process orders generated from the contract physician visit including faxing orders to the pharmacy and changing any affected residents' MARs. - The physician routinely provided written orders for any new or changed medications on the day of the visit, but did not provide the printed 	D 358		

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D 358	<p>Continued From page 15</p> <p>physician's visit summary for each resident on the day of the visit.</p> <ul style="list-style-type: none"> - The printed physician's visit summary for each resident seen on the last visit was routinely provided to the facility with the next scheduled 2 week visit. - The SCUC stated she reviewed the printed physician's visit summary for residents when she received them 2 weeks later, however she did not routinely monitor the medications listed or changed on the visit summary. - The SCUC stated she did not closely review the visit summary because the physician routinely wrote out a separate order for the medications or treatments changed or added on separate order forms. - The SCUC stated she was aware that electronically sign orders were valid orders, but she had not considered the electronically signed physician visit summary as an order. - Resident #12 had another order changed on 9/02/15 when the contract physician generated the visit form, but that order had a separate prescription order which was faxed to the pharmacy and transcribed to the September MAR. - The SCUC stated she did not routinely send the residents' printed physician's visit summary to the contract pharmacy for review. - The SCUC faxed a verification for Invokana 300 mg or Invokana 100 mg to the contract physician. <p>Interview on 10/01/15 at 9:20 am with a dayshift Medication Aide (MA) for the Special Care Unit revealed:</p> <ul style="list-style-type: none"> - The MA administered medications according to the MAR. - Resident #12 was administered Invokana 300 mg as ordered on the MAR. - The MA was not aware Resident #12 had an 	D 358		

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D 358	<p>Continued From page 16</p> <p>order to change the Invokana 300 mg to Invokana 100 mg on 9/02/15.</p> <ul style="list-style-type: none"> - The Special Care Unit Coordinator (SCUC) routinely processed the orders (changed the MARs and faxed the orders to the contract pharmacy) generated from the contract physician's visits. <p>Attempted interview on 10/01/15 at 10:00 am with Resident #12's primary care physician was unsuccessful.</p> <p>Telephone interview on 10/01/15 at 10:04 am with a representative for the contract pharmacy provider for Resident #12's medications revealed:</p> <ul style="list-style-type: none"> - The pharmacy received the FL-2 dated 7/08/15 ordering Januvia 100 mg. - The pharmacy received the order dated 8/05/15 to discontinue Januvia 100 mg. - The pharmacy received the order dated 8/05/15 to start Invokana 300 mg one tablet daily. - The pharmacy had not received a copy of the physician's visit summary dated and electronically signed on 9/02/15 with documentation to "DISCONTINUE: Invokana 300mg oral tablet One tablet daily." - The pharmacy did not receive the documentation to "PRESCRIBE: Invokana 100 mg oral tablet, Take 1 pill by mouth QAM [every morning] X 1 month (30d). (STOP 300 MG)". - The pharmacy continued to dispense Invokana 300 mg one daily as ordered on 8/05/15. <p>Based on record review and observation on 10/01/15, Resident #12 was determined unable to provide reliable information.</p> <p>On 10/01/15 at 4:18 pm the SCUC provided a faxed response from Resident #12's facility contract physician documenting Resident #12</p>	D 358		

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D 358	Continued From page 17 should be receiving Invokana 100 mg every morning.	D 358		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, interviews and record reviews, 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 rule and regulations related to health care and infection prevention procedures.</p> <p>The findings are:</p> <p>A. Based on observation, interview, and record review, the facility failed to assure documentation of implementation of physician's orders for 2 of 3 sampled residents (Resident #9 and #12) related to checking fingerstick blood sugar (FSBS) and administering sliding scale insulin (SSI). [Refer to Tag D276, 10A NCAC 13F .0902(c)(3-4) (Type B Violation)].</p> <p>B. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control regarding the use of an glucometer (Brand A), not assigned to a resident,</p>	D912		

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D912	Continued From page 18 for obtaining fingerstick blood sugars more than one resident. [Refer to Tag 932, G.S. 131D 4.4A(b) Adult Care Home Infection Prevention Requirements (Type B Violation)].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or	D932		

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D932	<p>Continued From page 19</p> <p>dermatitis until the condition resolves.</p> <p>(2) Require and monitor compliance with the facility's infection control policy.</p> <p>(3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control regarding the use of an glucometer (Brand A), not assigned to a resident, for obtaining fingerstick blood sugars more than one resident.</p> <p>The findings are:</p> <p>Based on information provided by the facility, it was revealed there were 29 residents in the facility receiving fingerstick blood sugar checks (FSBS) with 17 of these residents located on the assisted living unit and 12 residents located in the Special Care Unit.</p> <p>Based on the current Center for Disease Control and Prevention (CDC) guidelines for infection control, the recommendations are that whenever possible blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for</p>	D932		

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D932	<p>Continued From page 20</p> <p>more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list the disinfection information, the glucometer should not be shared between residents.</p> <p>Review of the manufacturer's recommendations in the user's manual revealed the Brand A glucometer is recommended for single use but can be used for more than one person, but the meter must be disinfected after every use according to the manufacturer's label of an EPA (Environmental Protection Agency) approved disinfecting agent.</p> <p>Observation on 9/30/15 at 4:20 pm revealed:</p> <ul style="list-style-type: none"> - The facility had a medication treatment cart for the assisted living unit used to store the 17 resident's diabetic supplies. - No EPA approved germicidal/disinfectant wipes were observed on the diabetic treatment cart. - The treatment cart had 3 rows of individual pull-out plastic trays (approximately 4 inches deep) and 17 trays labeled with a resident's name. (The names matched residents identified for receiving FSBS). - The pull-out trays were in good repair and formed a tight fit in the slots. - Each of the 17 trays contained a glucometer, lancing pen, lancets for the pen, and diabetic strips for the corresponding brand of glucometer. - One drawer was labeled with a resident's name (no longer on the census at the facility) and contained a Brand A glucometer that was not labeled with a resident's name, lancets for a lancing pen, but did not contain a lancing pen. - 14 glucometers and lancing pens were labeled and located in the corresponding residents' trays. - Two of the plastic trays contained glucometers labeled for the corresponding resident but the 	D932		

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D932	<p>Continued From page 21</p> <p>lancing pens were not labeled.</p> <ul style="list-style-type: none"> - One tray contained an unlabeled glucometer and unlabeled lancing pen in addition to the corresponding diabetic strips and lancets for the pen. - No additional lancing pens were observed loose or out of place on the diabetic treatment cart. <p>Interview on 10/01/15 at 4:30 pm with the evening shift Medication Aide revealed:</p> <ul style="list-style-type: none"> - The facility had a glucometer assigned to each resident receiving FSBS. - The facility policy was not to share a glucometer for any resident other than the resident to which the glucometer was assigned. - The MA was responsible for obtaining FSBS for residents that were scheduled for FSBS before dinner. - The MA only used the glucometer assigned to a resident to obtain FSBS for the resident. - The last tray located to the far right in the 3rd row of tray was not currently used: the tray was labeled for a resident that she thought was discharged before she came to work over a year ago. - She was not aware the tray contained a Brand A glucometer and she had not used the Brand A glucometer for obtaining a FSBS for a resident. - She stated the Special Care Unit Coordinator (SCUC) was responsible for maintaining diabetic supplies for residents. <p>Review of the FSBS values stored in the glucometer's history of the Brand A glucometer not labeled with a resident's name revealed:</p> <ul style="list-style-type: none"> - Time and date were set correctly. - The most recent 51 FSBS values stored in the unlabeled glucometer were current from 9/07/15 to 9/29/15. - Multiple FSBS values in a short period of time or 	D932		

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D932	<p>Continued From page 22</p> <p>on the same day were recorded in the Brand A glucometer's history.</p> <ul style="list-style-type: none"> - Thirty five of the most recent FSBS values were consistent with FSBS values documented on Resident #10's Medication Administration record for September 2015. <p>Examples of multiple FSBS values recorded with a short period of time or on the same day are as follows:</p> <ul style="list-style-type: none"> - On 9/20 at 7:22 am - FSBS=79, - On 9/20 at 8:48 am - FSBS=248, - On 9/15 at 4:21 pm - FSBS=169, - On 9/15 at 5:05 pm - FSBS=171, - On 9/13 at 7:21 am - FSBS=121, - On 9/13 at 7:28 am - FSBS=343, - On 9/10 at 7:15 am - FSBS=274, - On 9/10 at 8:14 am - FSBS=118, - On 9/10 at 11:13 am - FSBS=264, - On 9/10 at 12:01 pm - FSBS=159, - On 9/10 at 5:30 pm - FSBS=132, - On 9/10 at 6:25 pm - FSBS=114, - On 9/10 at 9:08 pm - FSBS=219, - On 9/09 at 7:12 am - FSBS=110, - On 9/09 at 8:01 am - FSBS=134, - On 9/08 at 7:09 am - FSBS=81, - On 9/08 at 7:55 am - FSBS=115, - On 9/08 at 11:30 am - FSBS=135, - On 9/08 at 12:02 pm - FSBS=152, - On 9/08 at 5:22 pm - FSBS=66. <p>Interview on 10/01/15 at 5:00 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> - The facility policy was for each resident receiving FSBS to have a glucometer assigned to the resident and the glucometer was to be used on the assigned resident only. Staff should not be sharing glucometers. - The Special Care Unit Coordinator (SCUC) was responsible for ordering glucometers and 	D932		

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D932	<p>Continued From page 23</p> <p>supplies for residents.</p> <ul style="list-style-type: none"> - The facility had replaced residents' glucometers a few months prior to the survey. - The facility did not stock an EPA (Environmental Protection Agency) approved disinfecting agent for disinfecting and decontamination glucometers against blood borne pathogens because staff should not be sharing glucometers. - The facility routinely kept at least one new glucometer to use for a resident admitted without a glucometer. - The Administrator stated "Occasionally, a glucometer that had been replaced by a glucometer ordered for a resident would be returned to stock and could be used for another resident in an emergency situation." - Medication Aides had been instructed to use alcohol swabs to thoroughly clean glucometers before returning the glucometer to stock. - She was not aware alcohol could not be used for a disinfecting agent for glucometers. <p>Interview on 10/01/15 at 5:40 pm with the SCUC revealed:</p> <ul style="list-style-type: none"> - She had worked at the facility for several years; starting as a Personal Care Aide, then Medication Aide/Supervisor, and most recently as the SCUC when the former SCUC left. - She was responsible for ordering diabetic supplies, including glucometers. - She was not aware a Brand A glucometer, that was not assigned to a resident was on the assisted living diabetic treatment cart and had current readings. - The facility did not stock an EPA (Environmental Protection Agency) approved disinfecting agent for disinfecting and decontamination glucometers against blood borne pathogens because staff should not be sharing glucometers. - She did not currently have a system in place to 	D932		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL077011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2015
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NAME OF PROVIDER OR SUPPLIER HERMITAGE RET CNT OF ROCKINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 139 MALLARD LANE ROCKINGHAM, NC 28379
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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
D932	<p>Continued From page 24</p> <p>routinely monitor FSBS values stored in residents' glucometer history compared to FSBS values documented on the residents' MAR for consistency.</p> <hr/> <p>The facility provided a Plan of Protection on 10/01/15 or immediate action as follows:</p> <ul style="list-style-type: none"> - Label all meters and lancet pens (which has already been done). - Remove all extra meters from treatment carts. - One meter with several readings has been removed from the treatment cart. - In-service with Medication Aides and Supervisors for further education on infection prevention. - Check (glucometer) readings weekly to ensure accuracy of the meters compared to MARs. - The Administrator will check weekly with the assistance of the SCUC, and Director Resident Services. <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 15, 2015.</p>	D932		