

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/03/2015
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NAME OF PROVIDER OR SUPPLIER ULTIMATE FCH 9	STREET ADDRESS, CITY, STATE, ZIP CODE 2510 SANDERS DRIVE WILLOW SPRINGS, NC 27592
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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
{C 000}	<p>Initial Comments</p> <p>The Adult Care Licensure Section conducted a follow-up survey on 12/03/15.</p> <p>C 246 10A NCAC 13G .0902(b) Health Care</p> <p>10A NCAC 13G .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: TYPE A2 VIOLATION</p> <p>Based on interview and record review, the facility failed to notify the prescribing practitioner for 1 of 3 residents (#3) sampled related to high blood sugars including 4 consecutive blood sugars greater than 500 on one day resulting in the resident being hospitalized for symptoms of high blood sugar. The findings are:</p> <p>Review of Resident #3's current FL-2 dated 08/17/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included schizoaffective disorder and high functioning Asperger's. - The resident was oriented and independent with activities of daily living. - There was an order for Humalog insulin 12 units 3 times a day. (Humalog is a rapid-acting insulin that lowers blood sugar.) - There was an order for Lantus 20 units twice daily. (Lantus is a long-acting insulin that lowers blood sugar.) <p>Review of a telephone clarification order from the endocrinology Nurse Practitioner (NP) dated 08/17/15 revealed:</p> <ul style="list-style-type: none"> - There was an order to discontinue the Humalog and Lantus injections and restart the insulin 	{C 000}		

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

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C 246	<p>Continued From page 1</p> <p>pump. (An insulin pump is a medical device implanted under the skin and used for the administration of insulin. The pump can provide a continuous basal supply of insulin and bolus doses can be given based on blood sugars and carbohydrate counting.)</p> <ul style="list-style-type: none"> - There was an order for the resident to check his fingerstick blood sugar (FSBS) 4 times a day. <p>Review of a telephone order from the NP dated 09/03/15 revealed an order not to use Lantus insulin and continue using the insulin pump.</p> <p>Review of a verbal order from the endocrinology nurse practitioner (NP) dated 09/15/15 revealed:</p> <ul style="list-style-type: none"> - An order that it was okay for the resident to self-administer his insulin pump using Humalog insulin. - An order to call the NP if the blood sugar was <60 or >400. - The NP had signed and dated on 10/01/15 beside the verbal order taken on 09/15/15. - The NP did not note any changes to the order on 10/01/15. <p>Review of Resident #3's blood sugar monitoring log for November 2015 revealed:</p> <ul style="list-style-type: none"> - The FSBS was being checked 4 times a day at 8:00 a.m., 12:00 noon, 4:00 p.m., and 8:00 p.m. - The parameters of when the NP should be notified for FSBS <60 or >400 was not transcribed on the log. - The FSBS ranged from 71 - 594 from 11/01/15 - 11/30/15. - The FSBS was >400 on 15 occasions from 11/01/15 - 11/30/15. - The FSBS was >500 on 6 of those 15 occasions. - The FSBS was 594 (8:00 a.m.), 535 (12:00 noon), 587 (4:00 p.m.), and 536 (8:00 p.m.) on 	C 246		

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C 246	<p>Continued From page 2</p> <p>11/04/15.</p> <ul style="list-style-type: none"> - The resident was documented as being in the hospital on 11/05/15 and 11/06/15. - The FSBS was 538 on 11/09/15 at 8:00 p.m. - The FSBS was 538 on 11/10/15 at 8:00 a.m. - The FSBS was 495 (12:00 noon) and 404 (8:00 p.m.) on 11/11/15. - The FSBS was 415 (8:00 a.m.), 499 (12:00 noon), and 471 (8:00 p.m.) on 11/12/15. - The FSBS was 455 on 11/13/15 at 8:00 p.m. - The FSBS was 425 on 11/14/15 at 8:00 a.m. - The FSBS was 418 on 11/16/15 at 6:00 p.m. - The FSBS was 484 on 11/26/15 at 8:00 a.m. <p>There was no documentation on the blood sugar monitoring log that the NP was notified as ordered.</p> <p>Review of the October 2015, November 2015, and December 2015 medication administration records (MARs) revealed the parameters of when to contact the NP for FSBS <60 or >400 were not transcribed onto the MARs.</p> <p>Review of Resident #3's record revealed no documentation the endocrinology NP had been notified of any FSBS >400.</p> <p>Interview with Resident #3 on 12/03/15 at 8:25 a.m. revealed:</p> <ul style="list-style-type: none"> - He had to go to the hospital last month because his blood sugar "got real high". - He thought his insulin pump may have been in the wrong place. - They took the insulin pump out at the hospital. - He now takes insulin injections and checks his blood sugar about 4 to 5 times a day. - His blood sugar is running a little better now and can get as high as the 300s - 400s. - He thought he was supposed to see endocrinology doctor sometime this week. 	C 246		

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C 246	<p>Continued From page 3</p> <p>Review of hospital discharge instruction form dated 11/07/15 revealed:</p> <ul style="list-style-type: none"> - Resident #3 was to follow-up with endocrinologist in 1 week. - The resident was to stop using the insulin pump and switch back to subcutaneous insulin injections with Lantus and Humalog until the insulin pump could be checked by endocrinologist. <p>Review of a hospital discharge medication order list dated 11/07/15 revealed:</p> <ul style="list-style-type: none"> - The order list included Lantus insulin 20 units twice a day. - The order list included Humalog insulin 12 units 3 times daily with meals. <p>Interviews with a medication aide on 12/03/15 at 12:16 p.m. and 12:30 p.m. revealed:</p> <ul style="list-style-type: none"> - She had only worked at this facility since last Friday, 11/27/15. - The resident usually checked his blood sugar 4 times a day and she documented the reading on the blood sugar log. - She was not aware of the order dated 09/15/15 to call the NP if the FSBS was <60 or >400. - The resident's FSBS had not been beyond those parameters since she started working about a week ago. <p>Interview with the Supervisor on 12/03/15 at 12:25 p.m. revealed:</p> <ul style="list-style-type: none"> - She was not aware of the order to call the NP for blood sugar parameters. - It looks like the FSBS parameter order was handwritten on the September 2015 MAR when it was received on 09/15/15. - The order was probably not faxed to the pharmacy since it was not printing on the 	C 246		

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C 246	<p>Continued From page 4</p> <p>October, November, or December 2015 MARs.</p> <ul style="list-style-type: none"> - This was a transcription error and it was not included on the blood sugar monitoring logs either. - Staff would not have known to contact the physician without the order with parameters being transcribed on the MARs or the blood sugar log. - She was going to transcribe the order on the December 2015 blood sugar log now. - Staff have called the Supervisor a few times when the resident's blood sugar runs high but she did not document when they called her. - She has contacted the NP a few times for high blood sugars but she did not document the contact and she did not know the dates. - The NP was aware of Resident #3's hospitalization in November 2015 for high FSBS. - She had contacted the NP for an appointment after the hospital stay but the NP had not been able to see the resident yet because of the NP's schedule. - She thought the NP was supposed to see the resident next week to check his insulin pump to see if he could start using it again. <p>Telephone interview with the endocrinology Nurse Practitioner (NP) on 12/03/15 at 2:12 p.m. revealed:</p> <ul style="list-style-type: none"> - She had been seeing and following Resident #3 for a while including care of his insulin pump. - She was recently contacted (around 11/20/15) by a staff person (uncertain of staff name) at the facility about Resident #3's blood sugars running high. - She increased the Humalog insulin to 16 units before meals and at bedtime on 11/30/15 based on that information. - The resident's blood sugar runs high at times and he had always been an unstable diabetic. - The facility had contacted her a few times but 	C 246		

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C 246	<p>Continued From page 5</p> <p>she was not aware the resident's FSBS had been >400 on 15 occasions since November 2015.</p> <ul style="list-style-type: none"> - She was not contacted on 11/04/15 when the resident's blood sugar was > 500 on 4 different occasions that day. - She was contacted 1 to 2 days prior to the resident's hospitalization (on 11/05/15) about the resident's blood sugar being high. - She could not recall who she spoke with but she told them to check the insulin pump and if the FSBS continued to be high they should send the resident to the emergency room. - She was not contacted again until after the resident was discharged from the hospital in November 2015 to set up an appointment. - She was unable to see the resident at that time but planned to come to the facility next week to check the resident and his insulin pump. - The insulin pump was stopped while the resident was in the hospital but she would check it and may put the resident back on the insulin pump. - The resident was currently using Humalog and Lantus injections. <p>Review of a NP order dated 11/30/15 revealed an order to increase Humalog to 16 units before meals and at bedtime.</p> <p>Review of the December 2015 blood sugar monitoring log revealed the resident's FSBS ranged from 82 - 229 from 12/01/15 - 12/03/15 (8:00 a.m.)</p> <p>Interview with the Supervisor on 12/03/15 at 3:20 p.m. revealed:</p> <ul style="list-style-type: none"> - She recalled contacting the NP sometime before the resident went to the hospital on 11/05/15 because the resident needed new prescriptions. 	C 246		

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C 246	<p>Continued From page 6</p> <ul style="list-style-type: none"> - She told the NP at that time the resident's blood sugar had been running in the 300s. - The NP told her that the high blood sugar could be caused by the resident's diet or the insulin pump could be messed up. - The NP told her to have the resident check the insulin pump. - She and Resident #3 checked the insulin pump and it was working okay. - She did not document this contact with the NP or when they checked the insulin pump. - The medication aide texted her on the afternoon of 11/04/15 to let her know the resident's blood sugar was running high. - The medication aide made a texting error and typed that the resident's blood sugar was in the 300s instead of the 500s. - She did not contact the NP because at that time because she thought the FSBS was in the 300s. - The medication aide called her late during that night and said the FSBS was in the 500s so she told the medication aide to send the resident to the emergency room. <p>Telephone interview with a second medication aide on 12/03/15 at 3:25 p.m. revealed:</p> <ul style="list-style-type: none"> - She was not aware there was an order to contact the NP for low or high blood sugars for Resident #3. - She was on duty at the facility on 11/04/15 when Resident #3's blood sugar was greater than 500 on 4 occasions that day. - The resident was not acting any different that day. - He checked his blood sugar and it was high. - She advised the resident to lay down. - She sent a text to the Supervisor after the FSBS was checked around 5:00 p.m. and was still high. - The Supervisor would be responsible for 	C 246		

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C 246	<p>Continued From page 7</p> <p>contacting the NP.</p> <ul style="list-style-type: none"> - The resident came and got her from the staff room late during the night because he was feeling lightheaded. - She called the Supervisor late that night when the resident complained and told her that his FSBS was in the 500s. - Emergency Medical Services (EMS) was called and the resident was taken to the hospital during that night. - EMS checked the resident's FSBS when they came to the facility that night and EMS did not get a reading because his FSBS was too high. <p>Telephone interview with the Administrator/Registered Nurse on 12/03/15 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> - She took the verbal order from the NP on 09/15/15 with the blood sugar parameters. - She did not think the order was valid anymore since the resident was no longer on the insulin pump. - She contacted the NP prior to the resident going to the hospital in November 2015 because the resident felt like the insulin pump was not working properly and the resident's blood sugar was running high. - She did not recall the date she called and she did not document the contact with the NP. - She felt like they did what they were supposed to for the resident's high blood sugars. <p>Review of facility staff training records revealed:</p> <ul style="list-style-type: none"> - Diabetes training included parameters for low and high blood sugars. - Training information included: call the resident's physician if the resident has 3 or more blood sugars above 300 in a row or 2 or more below 70 in a row. 	C 246		

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C 246	<p>Continued From page 8</p> <p>Interview with the Supervisor on 12/03/15 at 4:55 p.m. revealed:</p> <ul style="list-style-type: none"> - She did not contact the Administrator about Resident #3's blood sugars being over 500 on 11/04/15. - She did not see and was not aware of any documentation of any staff contacting the NP about the resident's high blood sugars on 11/04/15. <p>Interview with Resident #3 on 12/03/15 at 5:38 p.m. revealed:</p> <ul style="list-style-type: none"> - His FSBS had been running in the 500s all day on 11/04/15. - The medication aide was aware it was high. - The Administrator was not at the facility that day. - He woke up in the early morning hours and his stomach was "on fire", he was nauseated, and his arms were "heavy". - He got the medication aide and told her he needed to the go to the hospital. - The medication aide called EMS. - When EMS checked his FSBS at the facility, he thought it was over 600. <hr/> <p>Review of the facility's plan of protection dated 12/03/15 revealed:</p> <ul style="list-style-type: none"> - Supervisor will transcribe the blood sugar parameters for Resident #3 on the blood sugar logs and the medication administration records (MARs). - The instructions transcribed will be contact the prescribing practitioner if the blood sugar is less than 60 or greater than 400 as ordered. - Supervisor will notify all staff about what to do when the resident's blood sugar is low or high. - Supervisor will document any contact with the resident's prescribing practitioner and any 	C 246		

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C 246	Continued From page 9 communication with facility staff when the resident's blood sugar is less than 60 or greater than 400. - Staff on duty and Supervisor will assure the prescribing practitioner is called each time. - More training with staff is needed to prevent any further risk. - Staff on duty will monitor the blood sugar logs daily. - Supervisor and/or the Administrator will monitor the blood sugar logs at least weekly to assure compliance. - Supervisor will review all current residents' records to ensure all health care needs are met for all residents. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 2, 2016.	C 246		
{C 912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care. The findings are: Based on interview and record review, the facility	{C 912}		

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{C 912}	Continued From page 10 failed to notify the prescribing practitioner for 1 of 3 residents (#3) sampled related to high blood sugars including 4 consecutive blood sugars greater than 500 on one day resulting in the resident being hospitalized for symptoms of high blood sugar. [Refer to Tag C246 10A NCAC 13G .0902(b) Health Care (Type A2 Violation).]	{C 912}		