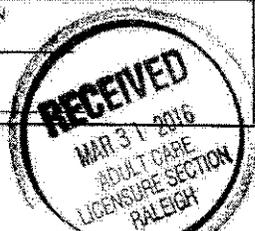


Division of Health Service Regulation



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011351	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/13/2016
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NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE FAMILY CARE HOME 6	STREET ADDRESS, CITY, STATE, ZIP CODE 11 ELLA LANE ALEXANDER, NC 28701
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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	Initial Comments The Adult Care Licensure Section conducted an annual survey and a follow-up survey on January 13, 2016.	C 000		
C 350	10A NCAC 13G .1005 (a) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, record review and interviews, the facility failed to evaluate and assure the mental and physical ability of 1 of 1 sampled residents (Resident #2) with a physicians order to self-administer Levemir and Novolog and Humalog insulins. The findings are: Review of Resident #2's current FL2 dated 6/15/15 revealed: -Diagnoses included Diabetes Mellitus II. -An order for finger stick blood sugars (FSBS)	C 350	self Admin. Evaluation Completed 1/15/16 Administrator will monitor weekly to ensure all supplies for proper use are on site at all times. the battery has been replaced on 1/13/16. Replacement batteries are available on site to assure that the battery can be replaced in a timely manner to avoid a repeat of this incident.	2/28/16 * annotated weekly for months missing for 3 months this randomly JRH 7/14/16

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE
Administrator

(X6) DATE
3/25/16

[Handwritten notes]
4/1/16 JRH

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011351	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/13/2016
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C 350	<p>Continued From page 1</p> <p>three times a day before meals.</p> <p>Continued review of the current FL2 revealed medications included: -Levemir, administer 36 units at bedtime (a long acting insulin used to lower high blood sugars) then increase by 1 unit every third day until FSBS stays below 130. -Humalog sliding scale insulin (a short acting insulin used to lower high blood sugars) three times a day before meals per results of the FSBS as follows: -FSBS greater than 150 = 1 unit. -FSBS greater than 200 = 2 units. -FSBS greater than 250 = 3 units. -FSBS greater than 300 = 4 units. -FSBS greater than 350 = 5 units. -FSBS greater than 400 = 6 units. -A physician's order for the resident to perform his own FSBS testing and to self-administer his insulin.</p> <p>Review of the Resident Register revealed Resident #2 had been admitted to the facility on 2/1/13.</p> <p>Review of a subsequent physician order dated 9/3/15 revealed an order for Victoza 1.2mg by injection daily. (Victoza is a non-insulin medication that helps lower blood sugars.)</p> <p>Review of subsequent physician orders dated 11/4/15 revealed: -Change Levemir from 36 units at HS to 16 units with breakfast and 16 units at bedtime. -Novolog Flexpen (a rapid acting insulin used to lower high blood sugars) inject 4 units with breakfast, lunch and dinner. -Check blood sugar three times daily with meals for sliding scale.</p>	C 350		

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C 350	<p>Continued From page 2</p> <ul style="list-style-type: none"> -Change Novolog insulin sliding scale to: -FSBS less than 50 = treat low blood sugar. Delay Novolog Flexpen injection until immediately after meal and reduce all Novolog insulin by 6 units. Notify physician. -FSBS 51-70 = immediately eat. Take injection just before eating reducing all Novolog insulin by 4 units. -FSBS 71-150 = Take prescribed dose of Novolog Flexpen insulin. -FSBS 151-200 = 2 units. -FSBS 201-250 = 4 units. -FSBS 251-300 = 6 units. -FSBS 301-350 = 8 units. -FSBS 351-400 = 10 units. -Greater than 401 = notify physician. <p>Review of subsequent physician orders dated 12/2/15 revealed:</p> <ul style="list-style-type: none"> -Discontinue the Victoza. -Continue FSBS testing before meals. -Change Novolog Flexpen to 4 units before breakfast and supper and 6 units at lunch. -Add FSBS testing at bedtime and use the following Novolog insulin sliding scale: -FSBS 151-200 = 0 units. -FSBS 201-250 = 2 units. -FSBS 251-300 = 2 units. -FSBS 301-350 = 6 units. -FSBS 351-400 = 8 units. -Greater than 401 = Notify physician. <p>Review of the most current Medication Review report from the facility pharmacy dated 10/15/15 revealed:</p> <ul style="list-style-type: none"> -The resident had been self-administering his own insulins. -The resident had been checking his own blood sugars. -A recommendation the facility complete a self 	C 350		

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C 350	<p>Continued From page 3</p> <p>administration evaluation for medication the resident was taking on his own. (This had not been done.)</p> <p>Review of the most current Licensed Health Professional Support Sheet (LHPS) dated 10/15/15 revealed: -Tasks included FSBS testing and injections. -The resident had been checking his own blood sugars and self administering his insulins. -There were no recommendations for the FSBS and sliding scale insulin.</p> <p>Review of Resident #2's Medication Administration Records (MARs) for November 2015 revealed: -"Self Admin" (self administration) had been hand written across the MAR after each of the insulin orders and the FSBS results area. . -There were no blood sugars documented for November 2015. -There were no doses of sliding scale insulin documented as administered for November 2015.</p> <p>Review of Resident #2's Medication Administration Records (MARs) for December 2015 revealed: -"Self Admin" (self administration) had been hand written across the MAR after each of the insulin orders and the FSBS results area. . -There were no blood sugars documented for December 2015. -There were no doses of sliding scale insulin documented as administered for December 2015.</p> <p>Review of Resident #2's Medication Administration Records (MARs) for January 2016 revealed: -"Self Admin" (self administration) had been hand written across the MAR after each of the insulin</p>	C 350		

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C 350	<p>Continued From page 4</p> <p>orders and the FSBS results area. .</p> <ul style="list-style-type: none"> -There were no blood sugars documented for January 2016. -There were no doses of sliding scale insulin documented as administered for January 2016. <p>Interview with Resident #2 on 1/13/16 at 10:10am revealed:</p> <ul style="list-style-type: none"> -Since becoming a diabetic, "about 6 years ago", he knew what to do to keep his blood sugars under control. -He was compliant with his diet and knew what to eat and what not to eat. -He could tell by how he felt if his blood sugar was high or too low. -When he felt his blood sugar was low, he would ask the staff for a teaspoon of peanut butter and they would get it for him. -He had been taught to take the peanut butter by a dietician when he first was told he had diabetes. -He had asked the staff several times in the past for peanut butter, but that had been just after he arrived (2013), not recently. -If he felt his blood sugar was too high, he would tell the staff and they would call his physician. -He stated his blood sugar had not been over 300 in "a long time". -He had been doing his FSBS testing and giving himself insulin for years. -His physician had written an order for him to check his own blood sugars and to self administer his own insulins -The insulin was labeled and came from the facility pharmacy -He kept the insulins in a refrigerator in his room. -He had his own FSBS testing machine which he kept in his room. -He kept a daily log, in his room, of the FSBS results and the amount of insulin he administered by sliding scale when needed. 	C 350		

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C 350	<p>Continued From page 5</p> <ul style="list-style-type: none"> -He had created this form himself. -He took this log with him when he went to see his doctor. -The facility staff did not check the log. -The facility staff did not check his FSBS testing machine. -At supertime on 1/1/16, the FSBS testing meter showed "low" and would not register a blood sugar result. -He realized, after several attempts to get a blood sugar reading, the battery needed to be replaced. -He thought he told the Administrator, "a day or two after that", and she stated she would get him a new one. -He had not received a new battery as of this interview. -He said he normally would have told the regular Medication Aide/Supervisor in Charge (MA/SIC), "but she had been out sick a lot." -One of the staff from another home brought over a battery from another FSBS testing machine but it didn't fit. -He stated he had been going by how he felt and did not feel he had needed additional insulin. -Since admission, the staff had not watched him check his FSBSs or administer his insulins <p>Review of Resident #2's FSBS log revealed December 2015 FSBS results as follows:</p> <ul style="list-style-type: none"> -Breakfast: 72-119. -Lunch: 85-200. Additional insulin (2 units) had been administered on 12/21/15 for FSBS of 200. -Supper: 70-207. Additional insulin (2 units) had been administered on 12/5/15 for FSBS of 181, 12/16/15 (2 units) for a FSBS of 185, and 12/28/15 (2 units) for FSBS of 207. -Bedtime: 74-292. Additional insulin (4 units) given 12/12/15 for a FSBS of 292. <p>Review of Resident #2's FSBS log revealed</p>	C 350		

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NAME OF PROVIDER OR SUPPLIER: WOODLAND TERRACE FAMILY CARE HOME 6
STREET ADDRESS, CITY, STATE, ZIP CODE: 11 ELLA LANE ALEXANDER, NC 28701

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C 350	<p>Continued From page 6</p> <p>January 1-13, 2016 FSBS results as follows: -There were 48 FSBS opportunities and 2 documented results. -On 1/1/16, Breakfast = 140 and Lunch = 120. -From 1/1/16 at 4:00pm through 1/13/16 at lunch, no results had been documented due to the FSBS testing machine not working.</p> <p>Interview on 1/13/16 at 11:30pm with the Administrator revealed: -Resident #2 had not told her he needed a battery for his FSBS testing machine. -She had learned about the battery from the MT/SIC on 1/12/16. -She had purchased a battery and had it with her that morning to take to Resident #2. -She did not ask Resident #2 routinely about needing supplies or if his equipment was working. -She did not review Resident #2's FSBS log. -She stated the physician had been making a lot of changes to Resident #2's insulins. -She looked at the current FSBS log and stated they were pretty stable now. -She stated Resident #2 should not have been without a functioning FSBS testing machine.</p> <p>Interview on 1/13/16 at 11:40am with the MA/SIC revealed: -Resident #2 told her on 1/12/16 that he needed a battery for his FSBS testing machine. -She immediately told the Administrator who said she would stop and get one on her way to the facility the next morning. -She did not review Resident #2's FSBS log. -When a log was completed, she placed it in the resident's record. -She had made him a log sheet but he made his own which was easier for him to use. -She did not check Resident #2's equipment or monitor the temperature of the refrigerator in his</p>	C 350		

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NAME OF PROVIDER OR SUPPLIER
WOODLAND TERRACE FAMILY CARE HOME 6

STREET ADDRESS, CITY, STATE, ZIP CODE
**11 ELLA LANE
ALEXANDER, NC 28701**

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C 350	Continued From page 7 room where the insulin was stored until use. -She had not and did not observe the resident's injection technique or infection control practices. -She did not know if Resident #2's physician had been informed of the resident's inability to check his FSBS since 1/1/16 at 4:00pm. -She stated the staff needed to check on the resident's equipment and FSBS log on a regular basis so something like this "doesn't happen again." Attempted telephone interviews on 1/13/16 at 11:10am and 3:25pm to Resident #2's physician's office were not returned by exit. A Plan of Protection provided by the facility on January 13, 2016 included the following: -The battery has been replaced. -The Administrator will monitor weekly to ensure all supplies for proper use are on site. -The Administrator will find out what the battery life is exactly for the make and model of the glucometer (FSBS testing machine). -The Administrator will assure the battery is replaced in a timely manner to avoid a repeat of this incident. -The Administrator will document on the MAR when the checking and follow-up has occurred. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 28, 2016.	C 350		
C 381	10A NCAC 13G .1009(b) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or	C 381	Administrator will assure that all pharmacy recommendations are followed up with immediately within 24 hours of initial	2/28/16

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C 381	<p>Continued From page 8.</p> <p>appropriate health professional has been informed of the findings when necessary.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure action was taken as needed in response to the medication review for 1 of 3 sampled residents (Resident #2) with pharmacy recommendations.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL2 dated 6/15/15 revealed: -Diagnoses included Diabetes Mellitus II. -An order for finger stick blood sugars (FSBS) three times a day before meals.</p> <p>Continued review of the current FL2 revealed medications included: -Levemir, administer 36 units at bedtime (a long acting insulin used to lower high blood sugars) then increase by 1 unit every third day until FSBS stays below 130. -Humalog sliding scale insulin (a short acting insulin used to lower high blood sugars) three times a day before meals per results of the FSBS as follows: -FSBS greater than 150 = 1 unit. -FSBS greater than 200 = 2 units. -FSBS greater than 250 = 3 units. -FSBS greater than 300 = 4 units. -FSBS greater than 350 = 5 units. -FSBS greater than 400 = 6 units. -A physician's order for the resident to perform his own FSBS testing and to self-administer his insulin.</p> <p>Review of the Resident Register revealed Resident #2 had been admitted to the facility on</p>	C 381	<p>recommendation.</p> <p>All follow up will be documented and filed in record for review by state county DSS.</p> <p>Self Admin Evaluation shall be completed in timely manner.</p> <p>Self Admin Evaluation will be completed for all medications that are being self administered once a month to assure proper self administration of medications.</p>	

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C 381	<p>Continued From page 9</p> <p>2/1/13.</p> <p>Review of the most current Medication Review report from the facility pharmacy dated 10/15/15 revealed:</p> <ul style="list-style-type: none"> -The resident had been self-administering his own insulins. -The resident had been checking his own blood sugars. -A recommendation the facility complete a self administration evaluation for medication the resident was taking on his own. <p>Review of Resident #2's record on 1/13/16 revealed no medication self-administration assessment could be located in the record</p> <p>Interview with Resident #2 on 1/13/16 at 10:10am revealed:</p> <ul style="list-style-type: none"> -His physician had written an order for him to check his own blood sugars and to self administer his own insulins -He had been doing his FSBS testing and giving himself insulin for years. -He kept a daily log, in his room, of the FSBS results and the amount of insulin he administered by sliding scale when needed. -He took this log with him when he went to see his doctor. -The facility staff did not check the log. -The facility staff did not check his FSBS testing machine. -Since admission, the staff had not watched him check his FSBSs or administer his insulins. <p>Interview on 1/13/16 at 11:57am with the nurse from the pharmacy responsible for the medication reviews revealed:</p> <ul style="list-style-type: none"> -She had just spoken with the facility MA/SIC (Medication Aide/Supervisor-in-Charge) and 	C 381		

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C 381	<p>Continued From page 10</p> <p>re-scheduled the medication review.</p> <ul style="list-style-type: none"> -She had completed the medication review on 10/15/15. -She had written the recommendation the facility complete a self-administration evaluation for Resident #2. -She would expect the facility to follow through on the recommendation. -She would follow-up on the recommendation when she returned to complete the January 2016 medication review. <p>Interview on 1/13/16 at 11:30pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -She was aware the pharmacy nurse had recommended the facility complete a self-administration evaluation for Resident #2. -Because the resident had been taking his own medication before his admission to the facility, she felt it had not been necessary. -The physician had written an order for the resident to self-administer his medications and she felt the medication self-administration evaluation had not been necessary. -She had not seen the resident self-administer his medication. <p>Interview on 1/13/16 at 11:40am with the MAVSIC revealed:</p> <ul style="list-style-type: none"> -She had seen the recommendation from the pharmacy nurse that the facility complete a self-administration evaluation for medication. Resident #2 was taking on his own. -She stated this had not been done because the resident had been taking his own medication before admission to the facility. -She felt it wasn't necessary because the physician had written an order for the resident to self-administer his medication. -She had not observed the resident 	C 381			

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PRINTED: 03/23/2016
FORM APPROVED

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C 381	Continued From page 11. self-administer his medication. Attempted telephone interviews on 1/13/16 at 11:10am and 3:25pm to Resident #2's physician's office were not returned by exit.	C 381		
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 observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations regarding the self-administration of medications. The findings are: Based on observation, record review and interviews, the facility failed to evaluate and assure the mental and physical ability of 1 of 1 sampled residents (Resident #2) with a physicians order to self-administer Levemir and Novolog and Humalog insulins [Refer to Tag C 350, 10A NCAC 13F .1004(a) (Type B Violation)].	C 912	Administrator will assure that all supplies for proper use are on site for self administration of medication. Administrator will assure that a self Administration evaluation is completed in a timely manner for self Administer orders of medications.	01/13/16