Association of Health Care Journalists

IMPROVING PUBLIC UNDERSTANDING OF HEALTH AND HEALTH CARE

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

WILMINGTON TREATMENT CENTER	**2520 TROY DRIVE WILMINGTON, NC 28401**	**Nov. 21, 2014**
VIOLATION: *FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE*		**Tag No:** A0724

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observations, review of manufacturer's recommendations for glucometer and staff interviews, the nursing staff failed to maintain the facility in a manner to ensure an acceptable level of safety and quality by failing to perform controls on a glucometer used for performing patient glucose checks (finger stick blood sugar checks) for one of one glucometer.

The findings include:

Interview on 11/19/2014 at 1400 with AS (Administrative Staff) #2 revealed no hospital policy for performing finger sticks or performing controls.

Review of Manufacturer's recommendations revealed "Use only Bayer's CONTOUR control solutions (Normal, Low or High) with your CONTOUR meter. Using anything other than CONTOUR control solution could present incorrect results. Run a control test: When using your meter for the first time; To check if you are testing correctly; When you open a new vial of test strips; If you leave the test strip vial open for an extended period of time; If you think your meter may not be working properly; or If your test results do not match how you feel....Compare your control test result with the Normal Control Range printed on the test strip bottle label or on the bottom of the test strip box....If your control test result is out of range, do not use your meter for blood glucose testing until you resolve the issue. ..."

Observation during tour on 11/18/2014 at 1415 revealed a Bayer CONTOUR blood glucose meter. Observation failed to reveal any control solutions or a log of control checks.

Interview with CNA (Certified Nursing Assistant) #4 on 11/18/2014 at 1415 revealed she had not performed controls on the meter. Interview revealed since "I have been here for the past 90 days, I have not seen an instruction book, no controls, or date

on top of test strips. I have not done controls at this job."

Observations on 11/19/2014 at 1145 revealed CNA #4 using a Bayer CONTOUR glucose meter to check a patient's blood glucose. Further observation revealed no control solution available.

Interview with AS (Administrative Staff) #2 on 11/19/2014 at 1430 revealed high, low and normal control solutions were now available. AS # 2 presented the control solutions and a control test log with a notation that controls were performed on 11/18/2014. Observation of the control solutions revealed the low and normal control solutions were out of date. Observation revealed the low control solution expired 6/2012 (2 years, 4 months ago) and the normal control bottle expired 7/2014 (3 months ago). Further interview with AS #2 confirmed the low and normal control solutions were out of date and should not be used. Interview revealed after surveyor finding of no controls, staff performed quality controls checks with expired control solutions on November 18,2014. Interview revealed the control solution was not available and no testing had been done prior to November 18, 2014.

Interview with AS #2 on 11/21/2014 at 1220 revealed new control solutions had been ordered on [DATE] but had not arrived.

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WILMINGTON TREATMENT CENTER	**2520 TROY DRIVE WILMINGTON, NC 28401**	**Sept. 21, 2017**
VIOLATION: *RN SUPERVISION OF NURSING CARE*		**Tag No:** A0395

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on policy and procedure review, "Basic Rules" review, consent review, medical record review, and staff interviews nursing staff failed to follow up on a positive urine drug screen for 1 of 10 medical records reviewed (Patient #1).

The findings include:

Review on 09/20/2017 of a policy titled "Search Policy and Procedure" last updated 04/2017 revealed "...Breathalyzer and Urine Quick-tox will be administered...on a random and /or for cause basis..."

Review on 09/21/2017 of "Basic Rules" revealed "...staff reserves the right to conduct random alcohol and drug screenings..."

Review on 09/21/2017 of "Consent for Treatment and Conditions of Admission" revealed "...Any such use of alcohol, prescribed and/or illicit contraband found in the possession of the patient will be removed and/or destroyed; patient will be discharged and/or prosecuted..."

Review of the closed medical record on 09/20/2017 of Patient #1 revealed a [AGE] year old female admitted on [DATE] to the detoxification unit for severe opioid use disorder. Review revealed Patient #1 signed the "Basic Rules" and "Consent for Treatment and Conditions of Admission" on 06/05/2017 at 2304. Review revealed on 06/13/2017 Patient #1 was transferred to the partial level hospitalization service. Review revealed on 06/18/2017 Patient #1 was ordered to start a new medication once a urine drug screen had been done. Review revealed on 06/18/2017 Patient #1's urine drug screen was negative and she was started on the new medication. Review revealed on 06/24/2017 a urine drug screen was done and indicated no use of prohibited substances. Review revealed an additional drug screen was done on 06/25/2017 at 2215 and was positive for marijuana. Review failed to reveal why the 06/25/2017 drug screen was done for Patient #1 and if any follow up was done by

nursing or clinical counselors about the positive drug screen. Review revealed Patient #1 continued treatment in the partial hospitalization level of care service and was discharged on [DATE].

The charge nurse on the night of 06/25/2017 was not available for interview during the survey.

Interview on 09/20/2017 at 1625 with Counselor #2 revealed random urine drug screens are done daily and patients were selected randomly by their record number.

Interview on 09/20/2017 at 0855 with Administrative Staff (AS) #1 revealed random urine drug screens were done during daytime hours. Review of the positive urine drug screen of Patient #1 with AS #1 revealed that because the urine drug screen was done at 2215 it would mean that it was a "for cause" drug screen. Further interview revealed AS #1 could not find in the medical record and did not recall why the 06/25/2017 drug screen had been done for Patient #1. Interview revealed AS #1 could not find in the medical record any follow-up regarding the positive result. Interview revealed the expected process for a positive drug screen was the staff that did the drug screen would notify the charge nurse of the results. Once notified of positive results by the staff the charge nurse would notify either the director of nursing (DON) or AS #1. The patient would then be transferred, administratively discharged , or placed on a contract for change. Interview revealed this was not done for Patient #1.

Interview on 09/20/2017 at1500 with Counselor #1 revealed he did not recall Patient #1 having a positive urine drug screen or being accused of selling or having illicit drugs. Interview revealed Patient #1 finished the full program and encouraged her peers.

Interview on 09/20/2017 at 1600 with the director of nursing (DON) revealed the certified nursing assistant who did the urine drug screen did not recall Patient #1 but if the urine drug screen was done at 2215 it would have been done for cause. Interview revealed the DON could not find in the medical record the reason why a drug screen was done on Patient #1 or what follow-up had been done after a positive drug screen.

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