Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	FCL060124		12/02/2015

NAME OF PROVIDER OR SUPPLIER
THE RADBOURNE MANOR II

STREET ADDRESS, CITY, STATE, ZIP CODE
7325 SWAN RUN ROAD
CHARLOTTE, NC 28226

(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 and Mecklenburg County Department of Social Services conducted an Annual Survey on 12/1/15 and 12/2/15.	C 000		
C 065	10A NCAC 13G .0312 (c) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance And Exits (c) At least one principal outside entrance/exit for the residents' use shall be at grade level or accessible by ramp with a one inch rise for each 12 inches of length of the ramp. For the purposes of this Rule, a principal outside entrance/exit is one that is most often used by residents for vehicular access. If the home has any resident that must have physical assistance with evacuation, the home shall have two outside entrances/exits at grade level or accessible by a ramp. This Rule is not met as evidenced by: Based on observation and interviews with staff and residents, the facility failed to maintain an accessible ramp located at the entrance of the facility for residents requiring physical assistance with evacuation. The findings are: Inteview on 12/1/15 at 11:00 am with the Administrator revealed the current total census was 4. Observation on 12/1/15 at 11:30 am of the facility's front porch entrance revealed: -A concrete sidewalk led up to the facility front porch.	C 065		

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

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C 065	Continued From page 1 -There were 2 brick steps approximately 3 foot wide from the concrete path to the front porch. Observation on 12/1/15 at 3:00 pm of the back porch entrance revealed: -There were 3 concrete steps leading to the back door entrance. -The back yard was fenced. Observations on 12/1/15 between 12:00 pm and 1:00 pm revealed; -One resident was assisted to the dining room table by a Medication Aide (MA). -The MA held the resident's hand and allowed the resident to follow behind her. -Another resident ambulated with a walker to the dining room table. Inteview on 12/1/15 at 12:30 pm with a MA revealed: -She was a MA and a Nursing Assistant (NA). -She had assisted residents to the dining room on 12/1/15. -One resident had a history of falls and now was using a walker to ambulate. -She was aware the facility did not have an outside ramp on either entrance to accommodate residents who required assistance with ambulation. -She was unsure how to get a resident out of the building if they required assistance or used a wheelchair. Observation on 12/2/15 of a storage room in the facility revealed 2 wheelchairs were located in the room. Telephone interview on 12/2/15 at 3:30 pm with construction revealed the facility was required to have ramps at both facility entrance and facility	C 065		

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C 065	Continued From page 2 exit for resident who could not ambulate by themselves. Interview on 12/2/15 at 4:30 pm with the Adminstrator revealed: -There had never been a ramp leading to the front or back facility entrances. -She was aware one resident required a walker for assistance with ambulation. -She was aware the MA assisted 2 residents with ambulation in the facility. -She had never been informed previously that the facility needed a ramp for residents requiring assistance with ambulation. -She would provide entrance/exit accessible ramps for residents who required assistance with evacuation to be in compliance with rules and regulations mandated by the state.	C 065		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.	C 185		

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C 185	Continued From page 3 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews the facility failed to ensure the Administrator was responsible for the total operations of the facility to maintain compliance in the rule areas including, Medication Administration, Health Care, and Infection Prevention Requirements. The Findings are: Interview on 12/2/15 at 5:00 pm with a Medication Aide revealed: -The nurse was responsible for reviewing orders and Medication Administration Records. -If she had a nursing question she would address to the facility nurse. -The nurse was available 24/7 by telephone if she was not in the facility. -If she had a question regarding the building or if a resident had a concern she would call the Administrator. -The Administraor was available 24/7 by telephone if she was not in the facility. -The Administrator was responsible for the total operations of the facility. Interview on 12/1/15 at 4:20 pm with Resident #2 revealed: -If he had a problem he would tell the MA or the Adminstrator. -He relied on the facility staff to meet his needs and provide care for him. -The thought the Adminstrator was responsible for the facility.	C 185		

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C 185	Continued From page 4 Interview on 12/2/15 at 5:20 pm with the facility nurse revealed: -She was in the facility daily and available for staff 24/7 by telephone. -She was responsible for the nursing staff and the training. -She was responsible for order clarifications, contacting the physicians, reviewing MAR monthly, and reviewing resident records. -She relied on the Adminstrator for day to day operations of the facility. Interview on 12/2/15 at 6:00 pm with the Administrator revealed: -She was responsible for day to day operations of the facility. -She was on call 24/7 for all the staff. -She had a Administrator in-training in the facility during the days. -She thought the staff would come to her with issues or concerns regarding day to day operations in the facility. The findings are: A. Based on observations, interviews, and record reviews the facility failed to ensure the Medication Administration Records (MARs) for 3 of 5 sampled residents (Resident #2, #3, and #5) included hydrocodone (an opioid narcotic used to treat moderate to severe pain), Humalog insulin (a fast acting insulin used to reduce blood sugar levels in the blood) and depakote (used to treat manic episodes related to bipolar disorder) were administered as ordered by the physican. [Refer to Tag 0330,10A NCAC 13G .1004(a) Medication Administration (Type B Violation).] B. Based on observations, interviews, and record reviews, the facility failed to assure physican	C 185		

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C 185	Continued From page 5 notification for 2 for 3 sampled residents (Resident #4 and #5) regarding low Finger Stick Blood Sugars (FSBS) for one Resident (#5) and the holding of olanzapine 15 mg (a antipsychotic used to treat schizoaffective disorders) for one Resident (#4) without a physican's order. [Refer to Tag 0246, 10A NCAC 13G. 0902 (b) Health Care (Type B Violation).] C. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Center for Disease Control Prevention guidelines on infection control regarding the use of sharing glucometers for multiple residents for 3 of 3 sampled residents (#1, #2, and #5).[Refer to Tag 0932, G.S. 131-D 4.4(b) Infection Prevention Requirements (Type B Violation).] D. Based on observation and interviews with staff and residents, the facility failed to maintain an accessible ramp located on the entrance of the facility for residents requiring physical assistance with evacuation.[Refer to Tag 0065, 10A NCAC 13G .0065(c) Outside Entrances and Exits.] E. Based on record review and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to Medication Administration, Infection Prevention Requirements, Health Care, Resident's Rights, and Management of Facilities.[Refer to Tag 0912, G.S. 131D-21 (2) Resident's Rights.] _____ The facility provided a Plan of Protection on 12/2/15 as follows:	C 185		

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C 185	Continued From page 6 -Immediately management will assure all staff at no risk potential harm. -The facility nurse will be in charge of overseeing the nursing staff as well as provide additional training on policy and procedures to all staff. -The nurse and the Administrator are in place to oversee the operations of the facility. . DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED January 16, 2016.	C 185		
C 246	10A NCAC 13G .0902(b) Health Care 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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physican notification for 2 for 3 sampled residents (Resident #4 and #5) regarding low Finger Stick Blood Sugars (FSBS) for one Resident (#5) and the holding of olanzapine 15 mg (a antipsychotic used to treat schizoaffective disorders) for one Resident (#4) without a physican's order. The findings are: Review of Resident #5's current FL2 dated 11/6/15 revealed: -Diagnoses included altered mental status, anxiety, pain generalized, hypertension, and diabetes.	C 246		

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C 246	Continued From page 7 -A physician's order for Lantus insulin (a slow acting insulin used to reduce glucose levels in the blood) 16 units at 8:00 pm and 21 units at 8:00 am. -A physician's order for Novolog Flexpen (a fast acting insulin used to reduce glucose levels in the blood) sliding scale insulin (SSI) as follows: -FSBS 0-250 = no SSI -FSBS 251-300 = 4 units SSI -FSBS 301-350 = 6 units SSI -There were no physician's order for collecting FSBS on the FL2. Review of Resident #5's record revealed a physican signed 6 month renewal of medications order dated 11/6/15 for FSBS 4 times daily before meals and at bedtime. Review of Resident #5's Resident Register revealed Resident #5 was admitted to the facility on 7/13/15. Review of Resident #5's September 2015 Medication Administration Record (MAR) revealed: -An entry for FSBS on the MAR for 4 times daily scheduled at 7:30 am, 11:30 am, 4:30 pm, and 8:00 pm. -FSBS ranged from 35 to 355. -Examples of low FSBS were as follows: -On 9/1/15 at 7:30 am FSBS 56 -On 9/8/15 at 7:30 am FSBS 44 -On 9/10/15 at 7:30 am FSBS 37 -On 9/14/15 at 11:30 am FSBS 35 -On 9/25/15 at 8:00 pm FSBS 53 -No documentation Novolog SSI was administered with the above FSBS. -Documentation on the back of the MAR on 9/1/15 at 8:00 am, 9/8/15 at 8:00 am, and on 9/10/15 at 8:00 am Lantus insulin was held (blood	C 246		

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C 246	Continued From page 8 sugar low). -No interventions documented on back of the MARs for the low blood sugars. Further review of Resident #5 record revealed: -No documentation notification of the physican for low blood sugars for the month of September 2015. -No documentation of snack, orange juice, or glucose as given for low blood sugars for the month of September 2015. Review of Resident #5's October 2015 MAR revealed: -An entry for FSBS on the MAR for 4 times daily scheduled at 7:30 am, 11:30 am, 4:30 pm, and 8:00 pm. -FSBS ranged from 38 to 291. -Examples of low FSBS were as follows: -On 10/8/15 at 11:30 am FSBS 47 -On 10/8/15 at 4:30 pm FSBS 50 -On 10/16/15 at 7:30 am FSBS 47 -On 10/17/15 at 7:30 am FSBS 41 -On 10/21/15 at 7:30 am FSBS 47 -On 10/21/15 at 8:00 pm FSBS 54 -On 10/24/15 at 7:30 am FSBS 38 -On 10/28/15 at 8:00 pm FSBS 41 -No documentaion Novolog SSI was administered with the above FSBS. -Documentation on the back of the MAR on 10/8/15 at 8:00 pm, 10/21/15 8:00 pm, and 10/28/15 at 8:00 pm, Lantus insulin was held (blood sugar low). -Documentation on back of MAR on 10/24/15 Lantus 21 units was held for FSBS 37, rechecked FSBS 91 no time was documented. -Documented circled initial entries on front of the MAR on 10/16/15 at 7:30 am, 10/17/15 at 7:30 am, 10/17/15 at 7:30 am, 10/21/15 at 7:30 am, 10/21/15 at 8:00 pm, and on 10/28/15 at 8:00 pm	C 246		

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C 246	Continued From page 9 Lantus insulin was omitted. -No interventions documented on back of the MAR's for low blood sugars. Further review of Resident #5 record revealed: -No documentation notification of the physican for low blood sugars for the month of October 2015. -No documentation of snack, orange juice, or glucose as given for low blood sugars for the month of October 2015. Review of Resident #5's November 2015 MAR revealed: -An entry for FSBS on the MAR for 4 times daily scheduled at 7:30 am, 11:30 am, 4:30 pm, and 8:00 pm. -FSBS ranged from 23 to 312. -Examples of low FSBS were as follows: -On 11/8/15 at 7:30 am FSBS 40 -On 11/21/15 at 7:30 am FSBS 45 -On 11/21/15 at 4:30 pm FSBS 38 -On 11/21/15 at 8:00 pm FSBS 44 -On 11/22/15 at 8:00 pm FSBS 61 -On 11/23/15 at 7:30 am FSBS 23 -No documentaion Novolog SSI was administered with the above FSBS. -Documented circled initial entries on front of the MAR on 11/8/15 at 7:30 am the lantus insulin was omitted. -Documentation the MAR on 11/22/15 Lantus 16 units was administered at 8:00 pm. Further review of Resident #5 record revealed: -No documentation notification of the physican for low blood sugars for the month of November 2015. -No documentation of snack, orange juice, or glucose as given for low blood sugars for the month of November 2015.	C 246		

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C 246	Continued From page 10 Further review of Resident #5's record revealed: -Resident #5 was sent to a local hospital Emergency Room (ER) on 10/9/15 with lethargy, lightheadedness, and a blood sugar of 40 upon arrival to the ER. -"Hypoglycemia is likely medication induced" was documented in the discharge note from the hospital. -A hospital discharge on 10/11/15 with diagnoses of hypoglycemia and acute kidney injury. -Resident #5 returned to the facility on 10/11/15. -Resident #5 was sent to the ER again on 11/23/15 for low blood sugar of 23. -Documentation on the hospital discharge summary dated 11/25/15 Resident #5 was "living in a group home which did not have adequate medical supervision". -The family had requested [Resident #5] go back the the skilled nursing facility she originally came from. -Resident #5 was discharged from the hospital to a skilled nursing facility on 11/25/15. Interview on 12/2/15 at 12:15 pm with the Nurse Practitioner (NP) revealed: -She seen Resident #5 monthly in the facility, the last visit was 11/23/15. -She was aware Resident #5 was a diabetic. -She was unaware of the low FSBSs in September, October, and November 2015. -The facility staff never called or communicated with her in regards to Resident #5's low FSBSs. -She was not made aware Resident #5 went to the ER on 11/23/15 with a low blood sugar of 23 until she had arrived at the facility on 11/23/15 for a scheduled visit. -She had informed the facility staff and management on 11/23/15 her office had on call 24/7 services for any issues that pertained to residents.	C 246		

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C 246	Continued From page 11 -The facility staff should inform the NP if the FSBSs were low. Interview on 12/2/15 at 4:00 pm with the Adminstrator revealed: -She was aware Resident #5 was a diabetic. -She was aware Resident #5's FSBSs were low several times in the past few months. -The staff had contacted the NP multiple times to inquire about Resident #5's care. -Staff had not contacted the NP on 11/23/15 regarding Resident #5's low blood sugar of 23 because the NP was scheduled to come to the facility for a routine visit. Review of the facility communication book revealed: -Documentation the NP came to the facility to sign paperwork on 8/4/15 and Resident #5's FSBS was 36. -Documentation on 8/5/15 the NP was called by the facility staff in regards to Resident #5's FSBSs "were low all day". -No additional facility documentation of low FSBS was provided. Review of Resident #5's record revealed: -A facility form "verbal order" dated 11/21/15 and signed by the NP on 11/23/15 "very low blood sugars for the past two days" as follows: -On 11/20/15 at 7:30 am FSBS 48 -On 11/20/15 at 11:30 am FSBS 47 -On 11/20/15 at 4:30 pm FSBS 46 -On 11/2/15 at 8:00 pm FSBS 61 -On 11/21/15 at 7:30 am FSBS 45 -On 11/21/15 at 4:30 FSBS 38 -Please advise on the above low FSBS. -A signed NP order dated 11/23/15 for Resident #5, change Lantus (decreased to) 15 units in the am and 15 units in the pm Hold for blood sugars	C 246		

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C 246	Continued From page 12 less than 60, notify the NP if held. If blood sugar greater than 400 notify the NP. -A facility physican communication/clarification form dated 11/22/15 requesting clarification "What BS reading warrants a call to the MD/NP". Interview on 12/2/15 at 4:30 pm with the facility Nurse revealed: -She was hired 2 weeks ago. -She had seen Resident #5's NP once on 11/23/15. -She could not say why staff had not contacted the NP about Resident #5's low FSBS over the past 3 months. -She relied on the MA to inform her of issues with the residents and their medications. -She assumed the NP had reviewed Resident #5's FSBS when she came on her scheduled visits monthly. -She thought the NP was aware of Resident #5's low FSBS because she reviewed the medications and the MAR each visit. B. Review of Resident #4's current FL-2 dated 10/21/15 revealed: -Diagnoses included Schizoaffective disorder, and issues with chronic mental illness. -A physician's order for olanzapine 15mg (used to treat an atypical antipsychotic) -No frequency or route was documented for the olanzapine 15mg. Review of Resident #4's Resident Register revealed an admission date of 9/24/15. Review of Resident #4's November and December 2015 Medication Administration Record (MAR) revealed: -An entry for olanzapine 15mg one tablet at bed time.	C 246		

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C 246	Continued From page 13 -Olanzapine 15mg was not documented as administered for 3 days on 11/13/15, 11/14/15 and 11/16/15. -No documentation on the MAR as the reason why the medication was not administered. Telephone interview on 12/2/15 at 9:32 am with Resident #4's primary care physician revealed: -Resident #4 was seen in the physician office on 11/16/15 for a routine visit. -Physician told Resident #4 he was to continue to remain on the olanzapine 15mg. -The physician informed the facility via wrtten documentaion on 11/16/15 that Resident #4 was to remain on olanzapine 15mg as ordered. -The facility did not contact the physican's office requesting the olanzapine be stopped or held. -The physician expected the medications to be administered as ordered unless the office was contacted by the facility staff and the physician gave alternate orders. -The physician's office did receive a fax on 11/30/15 of a medication error report stating the olanzapine 15mg was not administered for 3-days in November, but was not aware the medication was held by the facility staff. Telephone interview on 12/2/15 at 9:46 am with Resident #4's Guardian revealed: -The Guardian had spoken to the facility nurse and requested the medication olanzapine 15mg be held for Resident #4. -Resident #4 had told the Guardian the medication made him feel funny and he could not sleep well. Review of a copy of the Medication Error report for Resident #4 dated 11/30/15 revealed the form was completed 19-days after the olanzapine	C 246		

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C 246	Continued From page 14 15mg was held for 3-days without a physician's order. Based on observation, record review and interviews on 12/1/15 at 3:30 pm, it was determined Resident #4 was not interviewable. _____ The facility provided a Plan of Protection on 12/2/15 as follows: -Immediately all residents' records will be reviewed regarding orders and recommendations. -The registered nurse will be in charge of overseeing the nursing staff as well as training. -The residents' records will be reviewed immediately and weekly by the registered nurse and the Administrator for the next 3 months. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED January 16, 2016.	C 246		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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:	C 330		

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C 330	Continued From page 15 TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure the Medication Administration Records (MARs) for 3 of 5 sampled residents (Resident #2, #3, and #5) included hydrocodone (an opioid narcotic used to treat moderate to severe pain), humalog insulin (a fast acting insulin used to reduce blood sugar levels in the blood) and depakote (used to treat manic episodes related to bipolar disorder) were administered as ordered by the physican. The findings are: A. Review of Resident #5's current FL2 dated 11/6/15 revealed: -Diagnoses included altered mental status, anxiety, pain generalized, hypertension, and diabetes. -A physician's order for hydrocodone 5/325 mg with no frequency documented. Review of Resident #5's record revealed a subsequent signed physican clarification order dated 11/23/15 for hydrocodone 5/325 mg take 2 tablets every 8 hours as needed (PRN). Review of Resident #5's record revealed a physican signed 6 month renewal of medications order dated 11/6/15 for hydrocodone 5/325 mg take 2 tablets every 8 hours as needed (PRN). Review of Resident #5's Resident Register revealed Resident #5 was admitted to the facility on 7/13/15. Review of Resident #5's computerized Medication Record Administration (MAR) for September 2015 revealed:	C 330		

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C 330	Continued From page 16 -An entry for hydrocodone 5/325 mg take 1/2 tablets three times daily at 8:00 am, 12:00 pm, and 8:00 pm. -From 9/1/15 to 9/3/15 at 8:00 am, 7 doses of hydrocodone 5/325 mg 1/2 tablets were documented as administered. -A handwritten entry dated 9/2/15 on the MAR for hydrocodone 5/325mg take 1 tablet 3 times daily. -Documentation from 9/2/15 at 8:00 pm through 9/30/15 at 8:00 pm that Resident #5 was administered hydrocodone 5/325 mg at scheduled times of 8:00 am, 12:00 pm, and 8:00 pm for a total of 85 times. -No documentation on the September MAR the effectiveness of the hydrocodone 5/325 mg during the time it had been administered in September 2015. Review of Resident #5's computerized MAR for October 2015 revealed: -A entry for hydrocodone 5/325 mg take 1 tablet three times daily as needed. -An handwritten entry on the MAR "Changed 9/2/15" for the hydrocodone 5/325 mg. -A second entry on the MAR for hydrocodone 5/325 mg take 2 tablets 3 times daily scheduled at 8:00 am, 12:00 pm, and 8:00 pm. -Documentation from 10/1/15 to 10/31/15, Resident #5 was administered hydrocodone 2 tablets at scheduled times at 8:00 am, 12:00 pm and 8:00 pm for a total of 88 times. -No documentation on the October 2105 MAR the effectiveness of the hydrocodone 5/325 mg during the time it had been administered in October 2015. -On 10/11/15 documentation Resident #5 refused to take the hydrocodone at 8:00 pm, but documented as administered at 10:45 pm. Review of Resident #5's computerized MAR for	C 330		

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C 330	Continued From page 17 November 2015 revealed: -An entry for hydrocodone 5/325 mg take 2 tablet three times daily as needed. -An entry hydrocodone 5/325 mg was scheduled at 8:00 am, 12:00 pm and 8:00 pm and documented as administered from 11/1/15 at 8:00 am through 11/3/15 at 8:00 pm for a total of 9 times. -No documentation on 11/4/15 at 8:00 am through 11/9/15 12:00 pm Hydrocodone 5/325 mg was administered. -Documentation on 11/9/15 at 8:00 pm hydrocodone 5/325 mg 2 tablets were administered. -Documentation Resident #5 was administered hydrocodone 5/325 mg 2 tablets scheduled three times daily 34 times in November 2015. -An entry for hydrocodone 5/325 mg "order clarified" on 11/19/15 as PRN three times daily. -Documentation on the November 2105 MAR the effectiveness of the Hydrocodone 5/325 mg as follows: -On 11/13/15 no time was documented as administered, results effective. -On 11/13/15 no time was documented as administered, results effective. -On 11/14/15 no time was documented as administered, results effective. -On 11/15/15 no time was documented as administered, results effective. -On 11/15/15 no time was documented as administered, results effective. -On 11/15/15 at 8:00 pm, results effective. -On 11/16/15 at 10:30 am, results effective. -On 11/17/15 at 5:30 pm, results effective. -On 11/17/15 at 3:20 pm, results effective. -No documentation of medcations administered after 11/23/15 at 8:00 am. Review of Resident #5's record revealed:	C 330		

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C 330	Continued From page 18 -Resident was sent out to the Emergency Room on 11/23/15 for a low blood sugar of 23. -She had been discharged on 11/25/15 from the hospital to a skilled nursing facility on 11/25/15. Telephone interview on 12/2/15 at 4:00 with Resident #5's Power of Attorney (POA) revealed: -Resident #5 was discharged on 11/25/15 from the hospital and currently was in a skilled nursing facility. -"The facility could not give adequate care to Resident #5". -Resident #5 would ask for pain medicine because "her legs hurt". -She never saw the MA administer pain medication to Resident #5. -Resident #5 complained the staff were not administering pain medication to her when she had ask for it. -She has not spoken to the staff or management concerning Resident #5 not getting pain medication because the staff was new. -She was aware Resident #5 was taking Tylenol for pain control. -She had relied on the facility to administer medications to Resident #5. Telephone interview on 12/2/15 at 10:00 am with the facility contracted pharmacy revealed: -On 8/28/15, the pharmacy received a prescription for Resident #5 for hydrocodone 5/325 mg one tablet 3 times daily as needed. -On 9/2/15, the pharmacy dispensed 90 hydrocodone 5/325 mg tablets to the the facility for Resident #5. -On 9/25/15, the pharmacy received a prescription for hydrocodone 5/325 mg take 2 tablets three times daily as needed for Resident #5. -On 9/25/15, the pharmacy dispensed 180	C 330		

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C 330	Continued From page 19 hydrocodone 5/325 mg tablets to the facility for Resident #5. -On 11/6/15, the pharmacy received a prescription for hydrocodone 5/325 mg take 2 tablets three times daily as needed for Resident #5. -On 11/9/15, the pharmacy dispensed 180 hydrocodone 5/325 mg tablets to the facility for Resident. -On 11/30/15, 114 hydrocodone 5/325 mg were returned to the pharmacy from the dispensed dated 11/9/15. Review of Resident #5's record revealed: -Resident was seen on an initial visit on 8/3/15 in the facility by the Nurse Practitioner (NP). -Documentation Resident #5's history of chronic pain in extremities, hip/pelvis, knee and lumbar spine since adulthood. -Symptoms and severity were documented as moderate. -Documentation the symptoms improved with lying down and improved with medications. -Diagnoses addressed included chronic pain secondary to osteoarthritis, pain medications added included Tylenol 650 mg every six hours PRN and Tramadol 50 mg 1 every six hours PRN for severe pain. -Hydrocodone 5/325 mg was not documented as medication ordered on the NP visit for 8/3/15. -The NP last documented visit for Resident #5 was on 11/23/15. Interview on 12/2/15 at 12:15 pm with the NP revealed: -She seen Resident #5 monthly in the facility since 8/3/15. -She received a communication form dated 11/23/15 from the facility for clarification of the hydrocodone 5/325 mg and the frequency.	C 330		

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C 330	Continued From page 20 -She was made aware on 11/23/15 the hydrocodone 5/325 mg had been administered to Resident #5 as scheduled three times daily at 8:00 am, 12:00 pm, and at 8:00 pm, not PRN as ordered. -She expected the facility staff to follow the order for the hydrocodone 5/325 mg 2 tablets three times daily as need for pain. -She had informed the facility staff and management on 11/23/15 her office had on call 24/7 services for any issues that pertained to a residents. Review on 12/2/15 of Resident #5's record revealed prescriptions for the same information regarding the dates, instructions, and quantities dispensed for the hydrocodone 5/325 mg as provided during the pharmacy interview on 12/2/15 at 4:30 pm. Interview on 12/1/15 at 2:15 and on 12/2/15 at 4:00 pm with the facility Nurse revealed: -She was hired 2 weeks ago. -She was in charge of overseeing the nursing staff as well as training. -She was responsible for reviewing all residents' MARs monthly. -She relied on the Medication Aides (MAs) to administer the medications to the residents as ordered by the physican. -She was made aware of the hydrocodone 5/325mg transcribed on Resident #5's MAR for scheduled instead of PRN as ordered on 11/18/15. -She was aware on 11/18/15 the MAs had administered the hydrocodone 5/325 mg three times daily to Resident #5 scheduled not PRN as ordered. Interview on 12/1/15 at 2:30 pm with the	C 330		

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C 330	Continued From page 21 Adminstrator revealed: -She was not aware the hydrocodone 5/325 mg was given as scheduled to Resident #5 and not PRN as ordered until a few weeks ago. -She hired a new facility nurse two weeks ago. -The facility nurse would be in charge of overseeing the nursing staff as well as training. -The facility nurse would be responsible for reviewing the MARs monthly and overseeing narcotic documentation. -She had completed an in-house investigation on 11/10/15, reporting the staff to the police department as well as the Health Care Personnel Registry. -Staff members were terminated on 11/6/15. B. Review on 12/1/15 of Resident #2's current FL2 dated 11/30/15 revealed: -Diagnoses included diabetes type II, and mental retardation. -A physician's order for Humalog Flexpen insulin 10 units subcutaneous if Finger Stick Blood Sugars (FSBS) between 100-175 with every meal. -An order for Humalog Flexpen insulin 12 units subcutaneous if FSBS greater than 175 with every meal. -A physician's order to check blood sugars two times daily. Review on 12/1/15 of Resident's #2's record revealed a physician's order for FSBS three times daily documented on the previous FL2 dated 8/20/15. Review of Resident #2's October 2015 Medication Administration Record (MAR) revealed: -FSBSs were documented as obtained three times daily at 8:00 am, 12:30 pm, and 6:00 pm.	C 330		

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C 330	Continued From page 22 -FSBS ranged from 78-386. -On 10/6/15 at 8:00 am, FSBS 178, documented 10 units of Humalog insulin was administered, should have received 12 units. -On 10/9/15 at 6:00 pm, FSBS 173, documented 12 units of Humalog insulin was administered, should have received 10 units -On 10/24/15 at 6:00 pm, FSBS 103, documented 12 units of Humalog insulin was administered, should have received no insulin. Review of Resident #2's November 2015 MAR revealed: -FSBSs were documented as obtained three times daily at 8:00 am, 12:30 pm, and 6:00 pm. -FSBS ranged from 98-417. -On 11/5/15 at 6:00 pm, no FSBS documented on the MAR, 12 units of Humalog insulin was documented as administered. -On 11/13/15 at 6:00 pm, FSBS 298, documented 10 units of Humalog insulin was administered, should have received 12 units. -On 11/15/15 at 12:30 pm, documentation Resident # 2 was out of facility (OOF), 12 units of humalog insulin was documented as administered. -On 11/16/15 at 6:00 pm, FSBS 261, no documentation humalog insulin was administered, should have received 12 units. -On 11/20/15 at 8:00 am, FSBS 319, documented 10 units of humalog insulin was administered, should have received 12 units. -On 11/20/15 at 6:00 pm FSBS 285, no documentation humalog was administered, should have received 12 units. Interview on 12/1/15 at 4:20 pm with Resident #2 revealed: -He had been a diabetic for several years. -Staff had checked his blood sugar three times	C 330		

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C 330	Continued From page 23 daily, but now staff checked his blood sugar two times daily. -He would sometimes sign out of the facility and walk with another resident around the neighborhood. -He was aware he had insulin injections if his "sugar is high". -He relied on staff to administer his medications and to check his FSBS. Interview on 12/1/15 at 11:00 am and on 12/2/15 at 2:30 pm with a first shift MA revealed: -She had been employed for 2 weeks. -Her duties included medications administration and obtaining FSBS for the residents. -She was aware Resident #2 had orders for Humalog insulin coverage. -She compared Resident #2's FSBS results to the MAR to determine the amount of insulin he was to have administered with meals. -She would document the FSBS and the amount of Humalog insulin on Resident #2's MAR each time she checked FSBS and administered insulin. -At the end of every month the MAR would be reviewed by the Supervisor-in-charge and the facility nurse prior to filing the MAR in the resident's record. Interview on 12/1/15 at 2:15 and on 12/2/15 at 4:00 pm with the facility nurse revealed: -She was new to the facility. -She was in-charge of overseeing the nursing staff as well as training. -She was responsible for reviewing the MAR monthly. -She relied on the MAs to administer the medications and to complete FSBS monitoring for the residents. -She was unaware the MAs had administered Resident #2's humalog insulin incorrectly	C 330		

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C 330	Continued From page 24 according to the physican order. Interview on 12/1/15 at 2:30 pm with the Adminstrator revealed: -She had terminated all staff in November 2015, and had hired all new staff in the facility 2 weeks ago. -She had hired a new nurse two weeks ago. -The facility Nurse would be in-charge of overseeing the nursing staff as well as training. -The nurse would be responsible for reviewing the MAR monthly. -She was unaware if Resident #2's MAR had been reviewed for accuracy prior to the survey on 12/1/15. -She was unaware of the inaccuracies on the MAR and the Humalog insulin dosages. C. Review of Resident #3's current FL-2 dated 2/25/15 revealed. -Diagnoses included acute mental status change, hypertension, hyperlipidemia, coronary artery disease, and status post stent placement in the past. Review of Resident #3's record revealed: -A physician's order dated 11/9/15 for depakote sodium 125mg (used to treat manic episodes related to bipolar disorders) 2 capsules twice a day. -The order dated 11/9/15 also added depakote sodium to be administered 125mg 1 capsule every day at noon. Review of Resident #3's November 2015 Medication Administration Record (MAR) revealed: -An entry for divalproex sodium (depakote sodium) 125mg 2 capsules twice a day at 8:00 AM and 8:00 PM administered as order.	C 330		

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C 330	Continued From page 25 -A hand written order entry for depakote sodium 125mg capsule at noon that started on 11/10/15. -No documentation that depakote sodium 125mg at noon was administered from 11/11/15 to 11/17/15 (8-days). Interview on 12/1/15 at 4:15 pm with the facility contracted pharmacy staff revealed: -They had received an order change for Resident #3 on 11/9/15 for depakote sodium 125mg 2 tabs twice a day and depakote sodium 125mg one every day at noon. -The order on 11/9/15 would be printed on the December 2015 MARs. Telephone interview on 12/2/15 at 10:00 am with Resident #3's physican office staff revealed: -The physician received a faxed medication error report on 11/30/15 at noon documenting Resident #3 failure to receive Depakote Sodium as ordered. -The physician was not notified until 20 days after the first missed dose of depakote sodium 125 mg via fax from the facility on 11/30/15. -There was no documentation in Resident #3's file that the physician was contacted regarding any missed dose of medication. -The physician expects medications to be administered as ordered or contacted prior to changes being made to Resident #3's drug regimen. -Based on observation, interviews and record reviews Resident #3 declined to be interviewed on 12/2/15. _____ The facility provided a Plan of Protection on 12/2/15 as follows: -Immediatley all resident's MARs will be reviewed regarding orders and discrepancies by the facility nurse.	C 330		

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C 330	Continued From page 26 -The nurse will be charge of overseeing the nursing staff as well as training staff on MARs and new orders. -The Adminstrator will be responsible for overseeing the nurse and this Violation. -The facility nurse will be responsible for reviewing all resident's MAR weekly checks for the next 3 months. -The Administrator for the next 3 months will oversee the nursing staff as well as the nurse to be in compliance with state rules and regulations. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED January 16, 2016.	C 330		
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 record review and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to Medication Administration, Infection Prevention Requirements, Health Care, and Management of Facilities. The findings are:	C 912		

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	FCL060124		12/02/2015

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C 912	Continued From page 27 A. Based on observations, interviews, and record reviews the facility failed to ensure the Medication Administration Records (MARs) for 3 of 5 sampled residents (Resident #2, #3, and #5) included accurate instructions of the administration of Hydrocodone (an opioid narcotic used to treat moderate to severe pain), Humalog insulin (a fast acting insulin used to reduce blood sugar levels in the blood) and Depakote (used to treat manic episodes related to bipolar disorder). [Refer to Tag 0330,10A NCAC 13G .1004(a) Medication Administration (Type B Violation).] B Based on observations, record reviews, and interviews the facility failed to ensure the Administrator was responsible for the total operations of the facility to maintain compliance in the rule areas including, Medication Administration, Residents' Rights, and Infection Prevention Requirements. [Refer to Tag 0185,10A NCAC 13G. 0601(a) Management and Other Staff (Type B Violation).] C. Based on observations, interviews, and record reviews, the facility failed to assure physican notification for 2 for 3 sampled residents (Resident #4 and #5) regarding low Finger Stick Blood Sugars (FSBS) for one Resident (#5) and the holding of olanzapine 15 mg (a antipsychotic used to treat schizoaffective disorders) for one Resident (#4) without a physican's order. [Refer to Tag 0246, 10A NCAC 13G. 0902 (b) Health Care (Type B Violation).] D. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Center for Disease Control Prevention guidelines on infection control regarding the use of sharing	C 912		

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C 912	Continued From page 28 glucometers for multiple residents for 3 of 3 sampled residents (#1, #2, and #5).[Refer to Tag 0932, G.S. 131-D 4.4(b) Infection Prevention Requirements (Type B Violation).]	C 912		
C 932	G.S. 131D 4.4A (b) ACH Infection Prevention Requirements 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	C 932		

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C 932	Continued From page 29 dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Center for Disease Control Prevention guidelines on infection control regarding the use of sharing glucometers for multiple residents for 3 of 3 sampled residents (#1, #2, and #5). The findings are: Observation on 12/1/15 at 11:30 am of the medication cart revealed: -Two glucometers were in the top drawer of the medication cart. -Both glucometers were the same brand and manufacturers. -One glucometer and the pouch were both labeled with Resident #1's name. -Another glucometer with the pouch labeled with Resident #2's name but the glucometer was not labeled. -No other glucometers were located in the medication cart. Observation on 12/2/15 at 11:00 am of the medication cart and the nurse station area revealed no PDI Super Sani-Clothes products in	C 932		

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C 932	Continued From page 30 the facility. A. Review on 12/1/15 of Resdient #1's current FL2 dated 10/1/15 revealed: -Diagnose included diabetes, seizures, and dementia. -An order for FSBS daily in the morning. Review on 12/1/15 at 11:15 am of Resident #1's November 2015 MAR revealed: -FSBS were documented once daily at 8:00 am. -Examples of FSBS documented on the November 2015 MAR are as follows: -On 11/1/15 at 8:00 am FSBS 128. -On 11/5/15 at 8:00 am FSBS 118. -On 11/20/15 at 8:00 am FSBS 143. -On 11/22/15 at 8:00 am FSBS 153. -On 11/24/15 at 8:00 am FSBS 136. -None of the FSBS matched entry in Resident #1's glucometer history for the same date and time. Review on 12/1/15 at 1:50 pm of Resident #1's glucometer memory revealed: -The meter was set to the current date and time. -There were multiple readings in Resident #1's glucometer's memory occurring at various times throughout the day. Examples included: -11/4/15 at 8:19 am and at 4:25 pm. -11/18/15 8:33 am and 7:31 pm. -11/19/15 at 9:35 am, 9:39 am, and 5:46 pm. -11/27/15 8:15 am and 10:26 am. -The following FSBS readings found in Resident #1's glucometer matched FSBS readings documented for the same date and time on Resident #2's MARs as follows: -11/18/15 at 7:31 pm FSBS 429 matched the FSBS documented on Resident #2's MAR for 6:00 pm on 11/18/15. -11/19/15 at 5:46 pm FSBS 285 matched the	C 932		

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C 932	Continued From page 31 FSBS documented on Resident #2's MAR for 6:00 pm on 11/19/15. -11/29/15 at 8:15 am FSBS 262 matched the FSBS documented on Resident's #2's MAR for 8:00 am on 11/29/15. Based on observations, interviews, and record review revealed Resident #1 was not interviewable. Refer to review on 12/1/15 of the manufacturer's warnings for the glucometer. Refer to interview on 12/1/15 at 11:00 am and on 12/2/15 at 2:30 pm with a first shift Medication Aide (MA). Refer to interview on 12/1/15 at 2:15 and on 12/2/15 at 4:00 pm with the facility nurse. Refer to interview on 12/1/15 at 2:30 pm with the Adminstrator. Refer to review on 12/1/15 of the manufacture label of the glucometer. Refer to review of the facility policy and procedure. _____ B. Review on 12/1/15 of Resident #2's current FL2 dated 11/30/15 revealed: -Diagnoses included diabetes type II, and mental retardation. -Order to check blood sugars two times daily. Review of Resident's #2's record revealed: -Order for FSBS three times daily documented on FL2 dated 8/20/15.	C 932		

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C 932	Continued From page 32 Review of Resident #2's Resident Registry revealed he was admitted to the facility on 9/25/15. Review on 12/1/15 at 3:00 pm of Resident #2's October 2015 Medication Administration Record (MAR) revealed: -FSBS were documented three times daily at 8:00 am, 12:30 pm, and 6:00 pm. -FSBS ranged from 78-386. -On 10/16/15 at 8:00 am FSBS 169, and on 10/19/15 at 8:00 FSBS 126 none of these FSBS matched entry in Resident #2's glucometer history for the same date and time. Review on 12/1/15 at 3:15 pm of Resident #2's November 2015 MAR revealed: -FSBS were documented three times daily at 8:00 am, 12:30 pm, and 6:00 pm. -FSBS ranged from 98-417. -On 11/20/15 at 6:00 pm FSBS 285. -On 11/22/15 at 12:30 pm FSBS 296 -On 11/29/15 at 8:00 am FSBS 252. -None of the FSBS matched entry in Resident #2's glucometer history for the same date and time. Review on 12/1/15 at 3:50 pm of Resident #2's glucometer's memory revealed: -There were multiple readings in Resident #1's glucometer's memory occurring at various times throughout the day. Examples included: -11/20/15 at 8:05 am, 11:50 am, 4:51 pm, 7:36 pm. -11/23/15 at 8:07 am , 10:47 am, 1:13 pm, 4:31 pm, 6:30 pm. -Memory in Resident #2's glucometer dated back to 7/27/15 at 1:00 pm. -Five memory readings for the month of July 2015.	C 932		

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C 932	Continued From page 33 -Sixteen memory readings for the month of August 2015. -Three memory readings for the month of September 2015. -Four memory readings for the month of October 2015. -November 2015 memory history readings started 11/19/15. -The following FSBS readings found in Resident #2's glucometer matched FSBS readings documented for the same date and time on Resident #5's MARs as follows: -10/16/15 8:36 am FSBS 47 matched the FSBS documented on Resident #5's MAR for 7:30 am on 10/16/15. Interview on 12/1/15 at 4:20 pm with Resident #2 revealed: -He had been a diabetic for several years. -Staff had checked his blood sugar three times daily but now staff checks two times daily. -He is unaware what glucometer staff use to check his FSBS. -He was aware he had insulin injections if his "sugar is high". -He relies on staff to administer his medications and to check his FSBS. Refer to review on 12/1/15 of the manufacturer's warnings for the glucometer. Refer to interview on 12/1/15 at 11:00 am and on 12/2/15 at 2:30 pm with a first shift Medication Aide (MA). Refer to interview on 12/1/15 at 2:15 and on 12/2/15 at 4:00 pm with the facility nurse. Refer to interview on 12/1/15 at 2:30 pm with the Adminstrator.	C 932		

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C 932	Continued From page 34 Refer to review on 12/1/15 of the manufacture label for the glucometers. Refer to review of the facility policy and procedure. _____ C. Review of Resident #5's current FL2 dated 11/6/15 revealed: -Review of Resident #5's current FL2 dated 11/6/15 revealed: -Diagnoses included altered mental status, anxiety, pain generalized, hypertension, and diabetes. Review on 12/1/15 of Resident #5's record revealed a physican signed 6 month renewal of medications order dated 11/6/15 for FSBS 4 times daily before meals and at bedtime. Further review of Resident #5's record revealed she had been discharged to another facility on 11/25/15. Review on 12/1/15 at 4:15 pm of Resident #5's October 2015 MAR revealed: -FSBS were documented four times daily at 7:00 am, 11:30 am, 4:30 pm and at 8:00 pm. -FSBS ranged from 41-350. -On 10/16/15 FSBS documented 47 on MAR matched Resident #2's glucometer memory on 10/16/15 8:36 am FSBS 47. Based on observation, and interviews, on 12/1/15 at 4:15 pm revealed Resident #5's glucometer was unavailable for review. Telephone interview on 12/2/15 at 4:00 with Resident #5's Power of Attorney (POA) revealed:	C 932		

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C 932	Continued From page 35 -Resident #5 was discharged on 11/25/15 from the hospital and currently was in a skilled nursing facility. -She had not picked up Resident #5's glucometer from the facility and was unsure where Resident #5's glucometer was. -She had relied on the facility to administer medications and check FSBS for Resident #5. Telephone interview on 12/2/15 at 10:00 am with the facility pharmacy revealed Resident #5 glucometer was not returned to pharmacy. Refer to review on 12/1/15 of the manufacturer's warnings for the glucometers. Refer to interview on 12/1/15 at 11:00 am and on 12/2/15 at 2:30 pm with a first shift Medication Aide (MA). Refer to interview on 12/1/15 at 2:15 and on 12/2/15 at 4:00 pm with the facility nurse. Refer to interview on 12/1/15 at 2:30 pm with the Adminstrator. Refer to review on 12/1/15 of the manufacture label on the glucometers. Refer to review of the facility policy and procedure. _____ Review on 12/1/15 of the manufacturer's warnings for the glucometers revealed the system is for one person use only, do not share the meter with anyone. Interview on 12/1/15 at 11:00 am and on 12/2/15 at 2:30 pm with a first shift MA revealed:	C 932		

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C 932	Continued From page 36 -She had been employed for 2 weeks. -Her duties included medications administration and obtaining FSBS for the residents. -She always used the glucometer labeled with the resident name for obtaining FSBS for that resident. -She cleaned the resident's individual glucometer before and after using with an "alcohol swab". -She had disinfected resident's individual glucometer the same way by using an alcohol swabs. -She had been trained by the previous facility nurse to clean the glucometers with alcohol. Interview on 12/1/15 at 2:15 pm and on 12/2/15 at 4:00 pm with the facility nurse revealed: -She was hired two weeks ago. -She relied on the Medication Aides (MA) to administer the medications and to obtain FSBS for the residents. -She thought the family had picked up all Resident #5's medications as well as the glucometer. -She was unaware of the sharing of glucometers between residents. -The staff were to use "alcohol swabs" to clean and disinfect the glucometers before and after usage. -She was unaware when the last inservice for diabetic training for the staff was conducted. Interview on 12/1/15 at 2:30 pm with the Adminstrator revealed: -The family had picked up Resident #5's glucometer. -Resident #5 had been discharged to another facility per the family request on 11/25/15. -She was unaware of the sharing of glucometers between residents. -The facility policy was every resident had their	C 932		

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C 932	Continued From page 37 own glucometer and it was used only on that individual resident. -She had hired all new staff in the facility. -They would immediately buy new glucometers for all diabetic residents and label the glucometer and the pouch with the resident's names. -They would immediately hold an in-service and discuss infection control, safety, and the policy of not sharing glucometers. Review on 12/1/15 of the manufacture label glucometer, How to Clean and Maintain a Blood Glucose Meter provided by the facility revealed: -A recommendation for cleaning using moist lint free tissue using a mild detergent or disinfectant solution such as bleach mixed with 9 parts water and / or wipe dry with alcohol swab. Review of the facility policy and procedure revealed residents should have their own glucometer and it was to be intended for individual use only. _____ The facility provided a Plan of Protection on 12/1/15 as follows: -Immediately the facility will purchase new glucometers for diabetic residents. -The staff will be immediately inservice on diabetic care and the sharing of glucometers. -The facility nurse will be responsible for monitoring all glucometers on every resident for the next 30 days and then quartile. -The nurse will be charge of overseeing the nursing staff as well as training. -The pharmacy reviews will include checking memory readings on the glucometers. -Adminstrator will oversee all the above to keep residents safe and to ensure residents are	C 932		

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C 932	Continued From page 38 protected. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED January 16, 2016.	C 932		