

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL020001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/22/2016
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NAME OF PROVIDER OR SUPPLIER CAROLINA CARE HOME # 1	STREET ADDRESS, CITY, STATE, ZIP CODE 4021 PISGAH ROAD ANDREWS, NC 28901
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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
D 000	Initial Comments The Adult Care Licensure Section and the Cherokee County Department of Social Services conducted an annual and follow-up survey on September 21-22, 2016.	D 000		
D 164	<p>10A NCAC 13F .0505 Training On Care Of Diabetic Resident</p> <p>10A NCAC 13F .0505 Training On Care Of Diabetic Residents</p> <p>An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:</p> <p>(1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.</p> <p>(2) Training shall include at least the following:</p> <p>(a) basic facts about diabetes and care involved in the management of diabetes;</p> <p>(b) insulin action;</p> <p>(c) insulin storage;</p> <p>(d) mixing, measuring and injection techniques for insulin administration;</p> <p>(e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;</p> <p>(f) blood glucose monitoring; universal precautions;</p> <p>(g) universal precautions;</p> <p>(h) appropriate administration times; and</p> <p>(i) sliding scale insulin administration.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled Medication Aides (Staff A) had received training on the care</p>	D 164		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Division of Health Service Regulation

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D 164	<p>Continued From page 1</p> <p>of diabetic residents prior to the administration of insulin.</p> <p>The findings are:</p> <p>Review of Staff A's personnel record revealed:</p> <ul style="list-style-type: none"> -A hire date of 5/04/10. -Staff A had successfully passed the written Medication Aide Test on 8/4/15. -Staff A had completed the Medication Clinical Skills evaluation on 6/2/15. -There was no documentation that Staff A had completed the diabetic care training required for Medication Aides (MAs). <p>Interview with the Administrator on 9/22/16 at 2:24pm revealed:</p> <ul style="list-style-type: none"> -Staff A, currently worked as a MA in the facility on the 3:30pm to 7:30am shift, a double shift. -Staff A had begun administering medications to residents as soon as she had taken the Medication Aide test and had completed her Medication Clinical skills checkoff. -The facility Nurse Consultant did not have any record of the diabetic care training for Staff A. -The facility Nurse Consultant was going to schedule the diabetic care training for Staff A within the next 2-3 weeks. -The Administrator and Administrator-In-Charge were responsible to ensure training requirements were met for all staff. <p>Attempted interview with Staff A on 9/22/16 at 3:00pm was unsuccessful.</p>	D 164		
D 287	<p>10A NCAC 13F .0904(b)(2) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service</p>	D 287		

Division of Health Service Regulation

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D 287	<p>Continued From page 2</p> <p>(b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to provide a place setting which included a knife, fork, and spoon for 10 of 10 residents.</p> <p>Interview with the Administrator on 9/21/16 revealed the facility had a census of 10 residents.</p> <p>Observation of the lunch meal on 9/21/16 at 12:30pm revealed: -There were 10 residents seated in the dining room. -The place setting included a fork and spoon for all 10 residents. -The meal consisted of a breaded beef patty, mashed potatoes, green beans, pineapple chunks and a slice of bread. -One resident was cutting the beef patty up with a spoon. -Another resident was holding the beef patty with both hands while he ate it. -The other 8 residents were eating the beef patty with a fork and without difficulty.</p> <p>Interview with the kitchen staff on 9/21/16 at 12:30pm revealed: -Staff cut up food for the residents if needed. -When asked why they did not provide knives to</p>	D 287		

Division of Health Service Regulation

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D 287	<p>Continued From page 3</p> <p>the residents she stated "they might use them on us." -If they asked for a knife they could have one. -Knives were available in the kitchen for the residents.</p> <p>Observation of the utensil drawer in the kitchen on 9/21/16 at 12:55pm revealed there were only 2 knives available.</p> <p>Observation of the place settings for the dinner meal on 9/21/16 at 4:10pm revealed there was only a spoon and fork for all 10 residents.</p> <p>Interview with the second shift kitchen staff on 9/21/16 at 4:10pm revealed the residents would normally get a knife if the meal required one.</p> <p>Confidential interviews with residents during the survey revealed: -They never received knives in their place settings. -"We do the best we can." -"It (a knife) would be nice to have if I wanted to use one." -"They cut up food for us if we ask." -He had never had a knife since he had lived in the facility. -"I use a spoon to cut up stuff." -"Having a knife would be nice." -They were never told why they did not have knives during meals. -They only received a spoon and fork for their place setting. -They did not need knives to eat the food served to them. -They had never asked anyone for a knife at their place setting.</p> <p>Interview with the Administrator-In-Charge on</p>	D 287		

Division of Health Service Regulation

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D 287	<p>Continued From page 4</p> <p>9/22/16 at 10:45am revealed: -She had worked in the facility since July 2010. -They had never had knives. -"I always cut up everyone's food." -She had never been asked by a resident for a knife. -There were 2 residents that got their meat cut up at each meal. -She cut up the meat to "make it easier for them." -When asked if there were any residents that were unsafe to have knives, she stated, "tempers flare at times, and in the mental state they are in, I'm not sure if I would trust any of them." -There was one resident that preferred to have only a spoon.</p> <p>Observation of the dining room on 9/22/16 at 11:00am revealed the place setting for all 10 residents included a fork, spoon and a knife.</p> <p>interview with the Administrator on 9/22/16 at 2:46pm revealed: -They had knives, but ran out. -She planned on purchasing more from a local store today. -Some residents did not want knives. -She could only think of one resident that would be unsafe to have a knife. -No resident had ever been assessed by a physician for safe use of knives.</p>	D 287		
D 366	<p>10A NCAC 13F .1004 (i) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration</p> <p>(i) The recording of the administration on the medication administration record shall be by the</p>	D 366		

Division of Health Service Regulation

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D 366	<p>Continued From page 5</p> <p>staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure proper documentation on the Medication Administration Record (MAR) immediately following the administration of medications for 2 of 2 residents (#1 and #5) observed during a morning medication pass.</p> <p>The findings are:</p> <p>Observation of the morning medication pass on 9/22/16 at 7:16am revealed: -Resident #1 received 10 oral medications and 1 nasal spray. -The Medication Aide (MA) administered the medications and did not initial the MAR indicating administration of the medications.</p> <p>Continued observation of the morning medication pass on 9/22/16 at 7:22am revealed: -Resident #5 received 3 oral medications. -The MA administered Resident #5's medications and did not initial the MAR indicating the administration of the medications.</p> <p>Review of the facility's MARs for September 2016 at 8:05am revealed none of the MAR's had been initialed as administered by the MA for the 8am medications on 9/22/16, including Resident #1 and #5's medications.</p>	D 366		

Division of Health Service Regulation

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D 366	<p>Continued From page 6</p> <p>Interview with the facility Administrator on 9/22/16 at 8:10am revealed: -MAs are to initial the MARs immediately after administering the medications. -The MA had to leave the facility that morning to take family members to school. -The MA was coming back to sign the MARs. -Another MA came in this morning to complete the 8am medication pass.</p> <p>Interview with the first MA at 8:15am on 9/22/16 revealed she normally initialed the MARs immediately after administering the individual residents' medications but had forgotten to do so today.</p> <p>Observation at 8:17am on 9/22/16 revealed the first MA initialed all the medications she had administered on the 8am medication pass.</p> <p>Review of the facility's policy on MAR documentation revealed the MARs are to be initialed immediately after medications are given to the resident.</p>	D 366		
D 371	<p>10A NCAC 13F .1004(n) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p>	D 371		

Division of Health Service Regulation

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D 371	<p>Continued From page 7</p> <p>Based on observations, record reviews, and interviews, the facility failed to assure proper infection control measures were used for 2 of 2 residents (#1 and #5) observed during a morning medication pass.</p> <p>The findings are:</p> <p>Observation of the morning medication pass on 9/22/16 at 7:16am revealed:</p> <ul style="list-style-type: none"> -Resident #1 received 10 oral medications and 1 nasal spray. -The Medication Aide (MA) popped Resident #1's medications directly into her bare hand. -the MA then handed the medications to Resident #1 who took them with orange juice from breakfast. -The MA then administered Resident #1's nasal spray, 2 sprays to each nostril, without putting on gloves, and without sanitizing her hands with an alcohol based hand sanitizer, or washing her hands with soap and water. -The MA did not wash her hands with soap and water or sanitize with an alcohol based gel after she had finished administering Resident #1's medications. <p>Continue observation of the morning medication pass on 9/22/16 at 7:22am revealed:</p> <ul style="list-style-type: none"> -Resident #5 received 3 oral medications. -The MA popped Resident #5's medications directly into her bare hand. -She did not wash or sanitize her hands prior to handling Resident #5's medications with her bare hand. -Before the surveyor could intervene, Staff A then handed the medications to Resident #5 who promptly took them. 	D 371		

Division of Health Service Regulation

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D 371	<p>Continued From page 8</p> <p>Observation of the medication cart at 7:23am on 9/22/16 revealed no souffle cups or measured medication cups were available anywhere on the cart.</p> <p>Interview with Staff A on 9/22/16 at 7:23am revealed: -She normally administered medications by popping them directly from the medication bubble packs into her hand, and then handing them to the resident to take. -"I guess we could put them in a souffle cup."</p> <p>At 7:24am on 9/21/16, Staff A went to a kitchen cabinet and obtained a stack of plastic souffle cups to continue the medication pass.</p> <p>Interview with another MA at 7:25am on 9/22/16 revealed: -The facility's policy on medication administration was to wash or sanitize hands between residents during the medication pass. -Medications should be popped from the medication bubble packs directly into a souffle cup and then administered to residents.</p> <p>Interview with the facility Administrator on 9/22/16 at 7:30am revealed: -MAs should pop the medications from the medication bubble packs directly into a souffle cup for administration. -The MAs should wash their hands between residents.</p> <p>Interview with the facility Administrator on 9/22/16 at 9:00am revealed: -All staff, including Staff A had infection control training on 9/16/16. -The nurse doing the training discussed proper hand washing and the use of gloves.</p>	D 371		

Division of Health Service Regulation

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D 371	<p>Continued From page 9</p> <p>Review of the facility's policy on medication administration dated 5/14/15 revealed: -"When giving medications in a care facility, put medications into a souffle cup." -"Do not touch medications." -"Wash hands between administration."</p> <p>Review of the facility's policy on proper use of gloves revealed: -"Staff will wear gloves when there is potential contact with bodily fluids," e.g. mucous from nasal passages. -"Do not wear the same pair of gloves for more than one resident." "Perform hand hygiene before and immediately after removing gloves."</p> <hr/> <p>On 9/22/16, the facility provided the following Plan of Protection: -Employees will be retrained on proper medication administration related to infection control. -This will include hand washing between residents, wearing gloves when administering nose sprays, eye drops, creams, etc. -Souffle cups will be used for all medication administrations, not bare hands.</p> <p>THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 6, 2016.</p>	D 371		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:</p>	D912		

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D912	<p>Continued From page 10</p> <p>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, 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 in the area of infection control.</p> <p>The findings are:</p> <p>A. Based on observations, record reviews, and interviews, the facility failed to assure proper infection control measures were used for 2 of 2 residents (#1 and #5) observed during a morning medication pass. [Refer to Tag D371 10A NCAC 13F .1004(n) Medication Administration (Type B Violation).]</p> <p>B. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucose meters without proper disinfection for 3 of 3 sampled residents, (#1, #2, and #4). [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation).]</p>	D912		
D932	<p>G.S. 131D-4.4A (b) ACH Infection Prevention Requirements</p> <p>G.S. 131D-4.4A Adult Care Home Infection</p>	D932		

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D932	<p>Continued From page 11</p> <p>Prevention Requirements</p> <p>(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:</p> <p>(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:</p> <ul style="list-style-type: none"> 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 dermatitis until the condition resolves. <p>(2) Require and monitor compliance with the facility's infection control policy.</p> <p>(3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.</p>	D932		

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D932	<p>Continued From page 12</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucose meters without proper disinfection for 3 of 3 sampled residents, (#1, #2, and #4).</p> <p>The findings are:</p> <p>Observation of the medication room on 9/21/16 at 12:10pm revealed:</p> <ul style="list-style-type: none"> -Three stacked plastic storage bins with each bin containing a resident's fingerstick blood sugar (FSBS) supplies. -The front of each bin was labeled with each resident's name but had faded so badly they were almost illegible. -An unlabeled case outside the plastic bins contained an unlabeled glucose meter and unlabeled lancing device. <p>Interview with Staff B, Medication Aide (MA), on 9/21/16 at 12:12pm revealed:</p> <ul style="list-style-type: none"> -Staff B believed the extra glucose meter was a spare and had never been used. -Staff B had never used this extra meter on any resident. -Staff B believed the extra glucose meter did not contain any batteries. -The only cleaning the MAs perform on the glucose meters was to wipe them down with a cotton ball soaked in alcohol, and they try do this after each use. 	D932		

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D932	<p>Continued From page 13</p> <p>Observation of the unlabeled extra glucose meter and supplies not in a plastic bin on 9/21/16 at 12:14pm revealed:</p> <ul style="list-style-type: none"> -The extra glucose meter had batteries and was functional. -The memory of the glucose meter had 9 FSBS readings that ranged from 91-137mg/dl. -The dates in the extra glucose meter ranged from 1/2/16 through 9/22/16. <p>Review of the manufacturer's recommendations for all three brands of glucose meters observed in the facility revealed:</p> <ul style="list-style-type: none"> -No manufacturer recommended cleaning or disinfecting their glucose meters with an alcohol based product. -All manufacturers recommended cleaning and disinfecting glucose meters with a commercially available disinfecting wipe. <p>A. Review of Resident #2's most recent FL2 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included type 2 diabetes and schizophrenia. -An order to checked FSBS weekly. -Three oral medications used to treat diabetes, Onglyza 5mg daily, metformin extended release 500mg, 2 tablets twice daily, and glimepiride 4mg daily. <p>A subsequent order on a physician's order sheet dated 6/28/16 changed the frequency of the FSBS checks to twice weekly.</p> <p>Observation of Resident #2's plastic bin on 9/21/16 at 12:15pm revealed:</p> <ul style="list-style-type: none"> -Resident #2's bin contained FSBS supplies which consisted of an unlabeled case, unlabeled glucose meter in the case, and an unlabeled lancing device in the case. 	D932		

Division of Health Service Regulation

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D932	<p>Continued From page 14</p> <p>-Another unlabeled lancing device was found in Resident #2's FSBS bin outside the case.</p> <p>-Resident #2's bin contained a FSBS log containing documentation of blood sugar readings.</p> <p>Review of Resident #2's FSBS log revealed FSBS readings that matched the resident's glucose meter reading except for the following: -8/25/16 at 8am, a FSBS reading of 110mg/dl was not in Resident #2's glucose meter. -8/18/16 before breakfast, an extra blood sugar reading of 233mg/dl in Resident #2's glucometer. -7/6/16 before breakfast, an extra blood sugar reading of 328mg/dl in Resident #2's meter.</p> <p>A review of Resident #2's entire FSBS log from 6/30/16 to 9/18/16 revealed a blood sugar range of 63mg/dl to 169mg/dl.</p> <p>Interview with Resident #2 on 9/21/16 at 2:50pm revealed: -Staff checked his FSBS "about twice a week." -They always used the same color glucose meter and lancet device. -As far as he knew, this was his own glucose meter and lancet device.</p> <p>Refer to interview with Staff B on 9/21/16 at 2:55pm.</p> <p>Refer to interview with Staff A (MA) on 9/21/16 at 3:25pm.</p> <p>Refer to interview with Staff C (MA/Supervisor) on 9/21/16 at 4:20pm.</p> <p>Refer to interview with the facility Administrator on 9/22/16 at 9:00am.</p>	D932		

Division of Health Service Regulation

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D932	<p>Continued From page 15</p> <p>B. Review of Resident #1's most recent FL2 dated 12/30/15 revealed: -Diagnoses included diabetes, hypertension, and allergic rhinitis. -An order to check Resident #1's FSBS twice daily. -A medication order for Humulin 70/30 25 units each morning, and 15 units each evening. (Humulin is a combination insulin product used to lower blood sugar levels in insulin dependent diabetics.)</p> <p>Observation of Resident #1's plastic bin on 9/21/16 at 12:15pm revealed: -Resident #1's bin contained FSBS supplies which consisted of a case labeled with the resident's name, an unlabeled glucose meter in the case, and an unlabeled lancing device. -Resident #1's FSBS log containing documentation of blood sugar readings was lying on a table, just in front of the plastic bin containing her FSBS supplies.</p> <p>Review of Resident #1's FSBS log revealed FSBS readings that matched the resident's glucose meter readings except for the following: -An extra FSBS reading of 428mg/dl on 8/15/16 at 3:53pm on the resident's glucose meter but not on the FSBS log. -An extra FSBS reading of 191mg/dl on 8/5/16 at 4:54am on the glucose meter, but not on the FSBS log. -An extra FSBS reading of 164mg/dl on 7/21/16 at 4:57am on the glucose meter, but not on the FSBS log. -An extra FSBS reading of 118mg/dl on 7/13/16 at 12:31pm on the glucose meter but not on the FSBS log. -The last reading noted on Resident #1's glucose meter was on 7/12/16 at 6:52am.</p>	D932		

Division of Health Service Regulation

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D932	<p>Continued From page 16</p> <p>Review of Resident #1's FSBS log readings from 7/12/16 to 9/21/16 revealed a range of 62 to 355mg/dl.</p> <p>Interview with Resident #1 on 9/21/16 at 2:50pm revealed: -Staff B usually performed her blood sugar checks. -As far as she knew, they always used to same glucose meter and lancing pen. -She believed the meter and pen were either dark blue or black.</p> <p>Interview with Staff B, (MA) on 9/21/16 at 2:55pm revealed she may have used the extra glucose meter but not the lancing device on Resident #1 if her meter did not work.</p> <p>Observation of Resident #1's glucose meter and lancing device on 9/21/16 at 12:10pm revealed the meter and lancing device assigned to her were black, and the other two meters and lancing devices in the other plastic bins were maroon in color.</p> <p>Refer to interview with Staff B on 9/21/16 at 2:55pm.</p> <p>Refer to interview with Staff A (MA) on 9/21/16 at 3:25pm.</p> <p>Refer to interview with Staff C (MA/Supervisor) on 9/21/16 at 4:20pm.</p> <p>Refer to interview with the facility Administrator on 9/22/16 at 9:00am.</p> <p>C. Review of Resident #4's most recent FL2 dated 1/21/16 revealed:</p>	D932		

Division of Health Service Regulation

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D932	<p>Continued From page 17</p> <p>-Diagnoses included hypertension, gastric reflux, depression, and esophageal stricture. -No order to perform FSBS and no diagnosis of diabetes.</p> <p>Review of Resident #4's record revealed: -No entry for FSBS on Resident #4's MARs for July, August, and September 2016. -No physician's order to perform FSBS on Resident #4</p> <p>Observation of Resident #4's plastic bin on 9/21/16 at 12:15pm revealed: -Resident #4's bin contained FSBS supplies which consisted of an unlabeled case, a glucose meter labeled with Resident #4's name in the case, and an unlabeled lancing device. -The plastic bin also contained a FSBS log with documentation of Resident #4's blood sugars.</p> <p>Review of Resident #4's FSBS log on 9/21/16 at 12:15pm revealed: -There we only two FSBS readings documented in the log, 7/6/16 at FSBS of 110, and 8/30/16, a FSBS of 189.</p> <p>Review of readings on Resident #4's glucose meter revealed: -There was only one FSBS in the glucose meter. -The reading was 189 on 8/30/16 at 3:50pm.</p> <p>Interview with the facility Administrator on 9/22/16 at 8:50am revealed: -Resident #4 never had an order for FSBS from the physician. -A family member requested FSBS be performed and bought the glucose meter, lancing device, and supplies herself. -The family member had diabetes, so the family member figured Resident #4 would also.</p>	D932		

Division of Health Service Regulation

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D932	<p>Continued From page 18</p> <p>-Facility staff will call Resident #4's physician and unless ordered, remove the glucose meter and lancing device for Resident #4 from the facility.</p> <p>Interview with Resident #4 on 9/22/16 at 9:30am revealed: -Staff "checked my FSBS when I want it checked." -"I'm not feeling bad, I just want it checked." -Staff check his FSBS once or twice a month. -He was not sure of the brand or color of his glucose meter or lancing device.</p> <p>Review of Resident #4's record revealed: -A hemoglobin A1c of 5.9% on 12/1/15, and a hemoglobin A1c of 5.9% on 6/1/16. -The normal range for hemoglobin A1c for this lab was <5.7%, and any level above that meant an increased risk of developing diabetes.</p> <p>Refer to interview with Staff B on 9/21/16 at 2:55pm.</p> <p>Refer to interview with Staff A (MA) on 9/21/16 at 3:25pm.</p> <p>Refer to interview with Staff C (MA/Supervisor) on 9/21/16 at 4:20pm.</p> <p>Refer to interview with the facility Administrator on 9/22/16 at 9:00am.</p> <p>_____</p> <p>Interview with Staff B on 9/21/16 at 2:55pm revealed: -Sometimes she would recheck resident's FSBS and not write it down anywhere. -She had never shared a glucose meter or lancing device between residents.</p>	D932		

Division of Health Service Regulation

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D932	<p>Continued From page 19</p> <ul style="list-style-type: none"> -She could not explain the discrepancies between the glucose meters and the FSBS logs. -They, (the MA) don't share glucose meters or lancing device with the sister facility next door. <p>Interview with Staff A on 9/21/16 at 3:25pm revealed:</p> <ul style="list-style-type: none"> -Each resident had their own glucose meter and lancing device. -The meters and lancing devices used to be labeled with residents' names. -Staff A could not explain the discrepancy between the glucose meters and the FSBS logs. -Staff A has rechecked residents' FSBS and not written it down anywhere. <p>Interview with Staff C on 9/21/16 at 4:20pm revealed:</p> <ul style="list-style-type: none"> -She had never used a resident's meter or lancing device on another resident. -She always used the supplies in the resident's plastic bin. -She could not explain the discrepancies in the glucose meters and FSBS logs. -She had never checked her own blood sugar with a resident's meter, "I have my own." -All the cases and meters used to be labeled. -She was not sure where the extra glucose meter came from. <p>Interview with the facility Administrator on 9/22/16 at 9:00am revealed:</p> <ul style="list-style-type: none"> -The facility's policy on infection control related to obtained FSBS was not to share any supplies between residents for obtaining FSBS including meters and lancing devices. -The facility just had a training on infection control and obtaining FSBS on 9/16/16 and all staff attended. -A Registered Nurse conducted the training and 	D932		

Division of Health Service Regulation

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D932	<p>Continued From page 20</p> <p>included a discussion of hand washing, when to wear gloves, obtaining FSBS, not sharing glucose meters or lancing devices, and cleaning the meters. -Facility staff cleaned the meters with an alcohol soaked cotton ball.</p> <p>_____</p> <p>On 9/21/16 the facility provided the following Plan of Protection: -All glucose meters and lancing devices have been replaced with new meters and lancing devices. -Staff will have an inservice on the proper use of glucose meters and documentation. -An inservice will be conducted on infection control policies and procedures. -The Administrator will monitor glucose meters to make sure they are properly labeled. -The Administrator will monitor glucose meter readings to ensure they match the documented FSBS for that resident.</p> <p>THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 6, 2016.</p>	D932		
D935	<p>G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency</p> <p>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.</p> <p>(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in</p>	D935		

Division of Health Service Regulation

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D935	<p>Continued From page 21</p> <p>an adult care home or successfully completed all of the following:</p> <p>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ol style="list-style-type: none"> a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. <p>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.</p> <p>(3) Within 60 days from the date of hire, the individual must have completed the following:</p> <ol style="list-style-type: none"> a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: <ol style="list-style-type: none"> 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled Medication Aides (Staff A) who was hired after 10/1/13 as a</p>	D935		

Division of Health Service Regulation

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D935	<p>Continued From page 22</p> <p>Medication Aide (MA), had successfully completed the 15 hour medication administration training.</p> <p>The findings are:</p> <p>Review of Staff A's personnel record revealed: -A hire date of 5/04/10. -Staff A had successfully passed the written Medication Aide Test on 8/4/15. -Staff A had completed the Medication Clinical Skills evaluation on 6/2/15. -There was no documentation that Staff A had completed the 15 hour medication training program.</p> <p>Interview with the Administrator on 9/22/16 at 2:24pm revealed: -Staff A, currently worked as a MA in the facility on the 3:30pm to 7:30am shift, a double shift. -Staff A had begun administering medications to residents as soon as he had taken the Medication Aide test and had completed her Medication Clinical skills checkoff. -Staff A had never received the 15 hour medication administration training. -The facility Nurse Consultant was going to schedule the training for Staff A within the next 2-3 weeks. -The Administrator and Administrator-In-Charge were responsible to ensure training requirements were met for all staff.</p> <p>Attempted interview with Staff A on 9/22/16 at 3:00pm was unsuccessful.</p>	D935		