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	HAL049016	A. BUILDING: _____ B. WING _____	R 09/23/2015

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OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on September 22 and 23, 2015.	{D 000}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, record reviews and interviews, the facility failed to serve therapeutic diets as ordered for 2 of 2 residents (#1 and #2) with orders for a pureed diet. The findings are: A. Review of Resident #1's current FL2 dated 10/09/14 revealed: -Diagnoses that included Alzheimer's disease, dementia and depression. -An order for mechanical soft diet. Record review revealed a Physician order dated 5/21/15 for a pureed diet for Resident #1 (no diagnosis). Review on 9/22/15 at 11:00am of the therapeutic diets posted in the kitchen revealed Resident #1	{D 310}		

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{D 310}	Continued From page 1 was on a pureed diet. Review of Tuesday's Week Five therapeutic spread sheet lunch menu included the following for pureed diets: -Meat sauce -Spaghetti noodles -Tossed lettuce salad and dressing -Bread -Cake Observation of the lunch meal on 9/22/15 at 12:15pm revealed: -Dietary Staff B served Resident #1 a lunch plate that contained pureed spaghetti noodles, sauce and a whole dinner roll (no vegetables). -When questioned by Surveyor, Dietary Staff B removed the roll from Resident #1's plate. -Resident #1 ate the pureed spaghetti without problems. Refer to interview with Dietary Staff B on 9/22/15 at 12:18pm. Refer to interview with Dietary Staff A on 9/22/15 at 12:20pm. Interview with the Director on 9/22/15 at 3:40pm revealed: -She had requested a pureed diet in May due to Resident #1 "cheeking" food, not chewing well due to having only had a few teeth which had resulted in weight loss. -The resident did not have any swallowing problems or choking issues and had been eating better since getting foods pureed. -She expected kitchen staff to puree all foods per physician orders and menus. B. Review of Resident #2's current FL2 dated	{D 310}		

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{D 310}	Continued From page 2 9/08/15 revealed: -Diagnoses that included dementia and high blood pressure. -A order for a pureed diet. Review on 9/22/15 at 11:00am of the therapeutic diets posted in the kitchen revealed Resident #2 was on a pureed diet. Review of Tuesday's Week Five therapeutic spread sheet lunch menu included the following for pureed diets: -Meat sauce -Spaghetti noodles -Tossed lettuce salad and dressing -Bread -Cake Observation of the lunch meal on 9/22/15 at 12:15pm revealed: -Dietary Staff B served Resident #2 a lunch plate that contained pureed spaghetti noodles, sauce and a whole dinner roll (no vegetables). -When questioned by Surveyor, Dietary Staff B removed the roll from Resident #2's plate. -Resident #2 coughed several times during the meal. Refer to interview with Dietary Staff B on 9/22/15 at 12:18pm. Refer to interview with Dietary Staff A on 9/22/15 at 12:20pm. Interview with the Director on 9/22/15 at 3:45pm revealed: -Resident #2 had recently been hospitalized due to dehydration and had not been eating well. -The resident had eaten better on a pureed diet while in the hospital so the Director had	{D 310}		

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{D 310}	Continued From page 3 requested a pureed diet for Resident #2 after returning to the facility. -Resident #2 did not have any teeth, did not have any swallowing problems or choking issues, and had been eating better since getting pureed meals. -She expected kitchen staff to puree all foods per physician orders and menus. _____ Interview with Dietary Staff B on 9/22/15 at 12:18pm revealed: -The cook usually also pureed the bread. -Dietary Staff B stated she did not pay any attention to the rolls not being pureed today because she "was nervous". Interview with Dietary Staff A on 9/22/15 at 12:20pm revealed: -She usually pureed the bread with milk for pureed diets. -She had not prepared a salad or an appropriate substitute with the pureed diets. -Today she "just forgot" because she "was running behind".	{D 310}		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all residents	D912		

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D912	Continued From page 4 received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to infection control. The findings are: Based on observations, record reviews, and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring for at least 3 of 17 residents [Resident #3, #5, #7] with orders for finger stick blood sugars (FSBS) by sharing glucometers (a device used to measure the glucose level in blood) with other residents. [Refer to Tag 932, G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (Unabated Type B Violation.)]	D912		
{D932}	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 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	{D932}		

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{D932}	Continued From page 5 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. (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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring for at least 3 of 17 residents [Resident #3, #5, #7] with orders for finger stick blood sugars (FSBS) by sharing glucometers (a device used to measure	{D932}		

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{D932}	Continued From page 6 the glucose level in blood) with other residents. The findings are: Observation on 9/22/15 between 3:00pm and 3:30pm of the facility glucometers revealed: -There were 17 glucometers. -Each of the diabetic residents had their own glucometer, lancing device, and case. -Two of three sampled residents' glucometers were found to have a dried dark red substance on the unit. The facility's Infection Prevention Policy recommended that each resident have their own blood glucose monitor and that monitors not be shared by more than one resident. A. Review of Resident #5's record revealed: -The current FL2 dated 6/17/15 included diagnoses of diabetes mellitus, acute kidney failure and hypertension and orders for diabetic testing twice daily. -An admission date of 6/17/15. -A physician order dated 8/31/15 to obtain finger stick blood sugar (FSBS) daily. Observation on 9/22/15 at 3:00pm of Resident #5's glucometer revealed: -A re-sealable storage bag with Resident #5's name on the bag. -An unlabeled glucometer, unlabeled glucometer case and unlabeled lancet device. -The correct date and time when the glucometer was powered on by the surveyor. -The glucometer's memory had 3 readings from August 24, 2015 to August 31, 2015. -The glucometer's memory had 18 readings from September 1, 2015 to September 22, 2015. -On September 19, 2015 there were 7 readings	{D932}		

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{D932}	Continued From page 7 ranging from 87 to 225 between 7:46am and 7:56am. -There were multiple readings, from August 25, 2015 at 7:48am to September 19, 2015 at 7:56am, that did not match Resident #5's Daily FSBS Record: 9/19/15 at 7:56am, results of 117 9/19/15 at 7:55am, results of 152 9/19/15 at 7:54am, results of 92 9/19/15 at 7:52am, results of 87 9/19/15 at 7:50am, results of 225 9/19/15 at 7:46am, results of 134 9/01/15 at 7:45am, results of 123 8/30/15 at 7:46am, results of 129 8/25/15 at 7:48am, results of 107 Review of Resident #5's Daily FSBS Record from August 24, 2015 to September 22, 2015 revealed: -Blood sugar checks were to be done every morning. -There were 8 FSBS results documented that were not on the resident's glucometer. Interview on 9/23/15 at 11:51am with Staff A, Medication Aide (MA), when asked about the 7 FSBS done on 9/19/15, revealed it would be possible to check 7 finger stick blood sugars in ten minutes if staff were sharing glucometers. Interview with Resident #5 on 9/23/15 at 12:43pm revealed: -The resident was alert and oriented. -The resident received FSBS once a day and did not have a personal glucometer to the resident's knowledge. -The resident "used to" have a glucometer but "lost it". -The resident was "not sure" but thought the facility used their own glucometer.	{D932}		

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{D932}	Continued From page 8 Refer to interview on 9/22/15 at 4:25pm with the Director. Refer to interview on 9/23/15 at 11:51am with Staff A, MA. Refer to interview on 9/23/15 at 12:31pm with Staff B, MA/Personal Care Aide (PCA). B. Review of Resident #3's record revealed: -The current FL2 dated 4/05/15 included a diagnosis of uncontrolled diabetes mellitus and orders for diabetic testing every morning. -An admission date of 5/06/13. -A physician order dated 8/01/15 to obtain FSBS twice daily at 7:30am and 5:30pm. Observation on 9/22/15 at 3:10pm of Resident #3's glucometer revealed: -A re-sealable storage bag with Resident #3's name on the bag. -A labeled glucometer, glucometer case and lancet device with Resident #3's name. -The correct date and time when the glucometer was powered on by the surveyor. -The glucometer's memory had 15 readings from August 24, 2015 to August 31, 2015. -The glucometer's memory had 31 readings from September 1, 2015 to September 22, 2015. -There were multiple readings, from September 12, 2015 at 7:27am to September 18, 2015 at 6:52am, that did not match Resident #3's Daily FSBS Record: 9/18/15 at 6:52am, results of 141 9/17/15 at 7:02am, results of 185 9/15/15 at 7:15am, results of 181 9/12/15 at 7:27am, results of 260 Review of Resident #3's Daily FSBS Record from	{D932}		

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{D932}	Continued From page 9 August 24, 2015 to September 22, 2015 revealed: -Blood sugar checks were to be done twice daily at 7:30am and 5:30pm. -There were 16 FSBS results documented for Resident #3 that were not on the resident's glucometer. Interview with Resident #3 on 9/23/15 at 12:25pm revealed: - Resident #3 was alert and oriented. - Resident #3 received FSBS twice a day. - To Resident #3's knowledge, the resident had never had a personal glucometer and thought the facility used a glucometer of their own. Refer to interview on 9/22/15 at 4:25pm with the Director. Refer to interview on 9/23/15 at 11:51am with Staff A, MA. Refer to interview on 9/23/15 at 12:31pm with Staff B, MA/PCA. C. Review of Resident #7's record revealed: -A current FL2 dated 9/15/15 included a diagnosis of diabetes mellitus and an order for diabetic testing daily. -An admission date of 7/08/05. Observation on 9/23/15 at 11:20am of Resident #7's glucometer revealed: -A re-sealable storage bag with Resident #7's name on the bag. -A labeled glucometer, glucometer case and lancet device with Resident #7's name. -An incorrect date and time of "01-01 0443pm" when the glucometer was powered on by the surveyor.	{D932}		

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{D932}	Continued From page 10 -The battery was replaced on 9/23/15 prior to checking the FSBS. -The glucometer's memory had 8 readings from August 24, 2015 to August 31, 2015. -The glucometer's memory had 23 readings from September 1, 2015 to September 23, 2015. -There were multiple readings, from September 11, 2015 at 7:51am to September 17, 2015 at 6:48pm, that did not match Resident #7's Daily FSBS Record: 9/17/15 at 6:48pm, results of 246 9/16/15 at 6:47pm, results of 212 9/16/15 at 7:36am, results of 216 9/15/15 at 6:06pm, results of 289 9/15/15 at 7:18am, results of 143 9/14/15 at 5:39pm, results of 334 9/13/15 at 9:54pm, results of 300 9/13/15 at 6:37pm, results of 401 9/12/15 at 7:04pm, results of 234 9/11/15 at 7:51am, results of 253 Review of Resident #7's Daily FSBS Record from August 24, 2015 to September 22, 2015 revealed: -Blood sugar checks were to be done every morning. -There were 7 FSBS results documented that were not on the resident's glucometer. Interview with Resident #7 on 9/23/15 at 12:37pm revealed: -Resident #7 was alert and oriented. -The MA "checks my sugar every morning" in the medication room. -To Resident #7's knowledge, the resident believed that the facility had a glucometer that was labeled with Resident #7's name. Refer to interview on 9/22/15 at 4:25pm with the Director.	{D932}		

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{D932}	Continued From page 11 Refer to interview on 9/23/15 at 11:51am with Staff A, MA. Refer to interview on 9/23/15 at 12:31pm with Staff B, MA/PCA. _____ Interview on 9/22/15 at 4:25pm with the Director revealed: -She could not believe the MAs were sharing glucometers and she was not aware they had been sharing. -There is no reason for staff to be sharing glucometers because each resident had their own individual glucometer available for use in the medication room. -There was a replacement glucometer in the facility to use in case an extra was needed. -If a glucometer had to be shared, the facility was able to clean the unit per manufacturer's instructions. -She was going to have additional training with the medication aides about infection control and not sharing diabetic equipment. -The medication aides knew not to share diabetic equipment...that was "cross contamination". Interview on 9/23/15 at 11:51am with Staff A, MA revealed: -She had always used each residents' own glucometer and lancing device. -She had never shared any resident's diabetic equipment. -She could not explain why the glucometer readings did not match the Daily FSBS Records. -She had never observed anyone sharing glucometers at this facility. -She had received diabetic training.	{D932}		

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{D932}	Continued From page 12 -She had taken the State mandated infection control training. -The facility has a "house glucometer" that could be used if a resident's glucometer malfunctions. Interview on 9/23/15 at 12:31pm with Staff B, MA/PCA revealed: -Each resident had their own glucometer and lancing device. -If a resident's glucometer was broken she would call the Director for instructions. -She did not share resident's diabetic equipment and had never observed another MA sharing glucometers, and stated "That's a no-no." -She had received diabetic training. -She had taken the State mandated infection control training. --- A Plan of Protection was submitted by the facility on 9/22/15 that included: -The Director will have an immediate inservice on Infection Control to prevent sharing of glucometers. -The Director will clean all diabetic equipment according to manufacturer's instructions. -The Director will conduct weekly checks to monitor glucometer usage.	{D932}		