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CARMEL HILLS	2801 CARMEL 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
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey on 12/8/15 to 12/19/15.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 4 of 5 sampled staff (Staff A, B, D, and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) according to G.S. 131E-256. The findings are: A. Review of Staff A's personnel records revealed: -Hire date of 11/30/15 as a food service aide. -No documentation of a HCPR check. Staff A was unavailable for interview. A HCPR check completed on 12/09/15 for Staff A revealed no substantiated findings were listed on the registry. Refer to interviews on 12/09/15 at 12:00 pm and 3:09 pm with the Office Manager.	D 137		

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D 137	Continued From page 1 Refer to interview on 12/09/15 at 2:45 pm with the Nursing Director. B. Review of Staff B's personnel records revealed: -Hire date of 03/06/15 as a dietary aide. -No documentation of a HCPR check. Staff B was unavailable for interview. A HCPR check completed on 12/09/15 for Staff B revealed no substantiated findings were listed on the registry. Refer to interviews on 12/09/15 at 12:00 pm and 3:09 pm with the Office Manager. Refer to interview on 12/09/15 at 2:45 pm with the Nursing Director. C. Review of Staff E's personnel records revealed: -Hire date of 02/08/02 as Dietary Manager. -No documentation of a HCPR check. Interview on 12/09/15 at 3:08 pm with Staff E revealed: -He was not aware of the requirements for checking the HCPR. -The Office Manager did all the paperwork for new employees. A HCPR check completed on 12/09/15 for Staff E revealed no substantiated findings were listed on the registry. Refer to interviews on 12/09/15 at 12:00 pm and 3:09 pm with the Office Manager.	D 137		

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D 137	Continued From page 2 Refer to interview on 12/09/15 at 2:45 pm with the Nursing Director. D. Review of Staff D's personnel records revealed: -Unable to determine Staff D's initial hire date. -Staff D became a Care Aide on 03/07/07. -Staff D became a Medication Aide on 12/20/11. -Documented HCPR check dated 03/16/15 with no substantiated findings listed. Interview on 12/09/15 at 3:05 pm with Staff D revealed: -She started working at the facility as a dietary aide in December 2005. -She was not aware of the requirements for HCPR checks. Interview on 12/19/15 at 3:00 pm with the Nursing Director revealed: -Staff D worked in the kitchen prior to becoming a Care Aide. -A HCPR check was not completed for Staff D upon hire because the Nursing Director did not know the HCPR check needed to be completed for staff who were not responsible for providing direct care for residents. -The HCPR check was completed when Staff D became a Care Aide. Refer to interviews on 12/09/15 at 12:00 pm and 3:09 pm with the Office Manager. Refer to interview on 12/09/15 at 2:45 pm with the Nursing Director. Interview on 12/09/15 at 12:00 pm with the Office Manager revealed: -She had worked at the facility for 22 years and had been the Office Manager since 1996.	D 137		

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D 137	Continued From page 3 -She completed the HCPR checks for new Care Aides and Medication Aides. -She was not aware a HCPR check needed to be completed for staff who were not responsible for providing direct care to residents. Interview on 12/09/15 at 2:45 pm with the Nursing Director revealed: -She and another nurse completed the HCPR checks for Care Aides and Medication Aides only. -She thought the HCPR check was not required for staff who did not provide direct care to the residents. On 12/19/15, the Administrator provided a Plan of Protection as follows: -Beginning immediately, the facility would audit all personnel records to ensure a HCPR check was completed for all current employees. -The facility would complete a HCPR check for all prospective employees before making an offer of employment. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 23, 2016.	D 137		
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 regulations. This Rule is not met as evidenced by:	D912		

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D912	Continued From page 4 Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding infection prevention requirements and other staff qualifications. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control (CDC) and Prevention guidelines on infection control for 3 of 4 sampled resident (Resident #2, #3, and #4) regarding sharing glucometers without proper disinfection of fingerstick blood sugar (FSBS) monitoring equipment and an unlabeled fingerstick lancing pen. [Refer to Tag 932, G.S. 131D-4.4A (Type B Violation).] B. Based on observations, interviews, and record reviews, the facility failed to ensure 4 of 5 sampled staff (Staff A, B, D, and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) according to G.S. 131E-256. [Refer to Tag 137, 10A NCAC 13F .0407(a)(5) (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	D932		

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D932	Continued From page 5 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 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	D932		

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D932	Continued From page 6 control procedures consistent with Centers for Disease Control (CDC) and Prevention guidelines on infection control for 3 of 4 sampled resident (Resident #2, #3, and #4) regarding sharing glucometers without proper disinfection of fingerstick blood sugar (FSBS) monitoring equipment and an unlabeled fingerstick lancing pen. The findings are: Observation on 12/08/15 at 11:20 am of the medication cart revealed: -There were a total of 4 black canvas pouches in the bottom right drawer of the medication cart, each one with a glucometer stored inside. -One pouch, unlabeled for a resident's name, contained a Brand B glucometer, test strips (No lancing pen). -Two of the 4 black canvas pouches were labeled with a resident's name and contained a Brand A glucometer, and test strips (No lancing pens). -One of the labeled black canvas contained a Brand A glucometer, labeled with a corresponding resident's name, test strips, and, a reusable lancing pen (unlabeled for resident's name) but no lancets for the pen. The tip of the lancing pen was visibly soiled with blood. Observation on 12/8/15 at 12:35 pm of FSBS monitoring for one resident revealed the Medication Aide (MA) used correct techniques in regards to infection control. Observation of the Brand A glucometer used by the MA, for the resident, revealed: -The glucometer was labeled on the back ,in black marker, with a resident's name but the name was faded and barely visible. -The name on the glucometer did not match the	D932		

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name on the black canvas pouch or the name of the identified resident.
-There was no lancing pen in the case.

Interview on 12/08/15 at 11:25 am with the Nursing Director (ND) revealed:
-The third shift MA was responsible to wipe down the glucometers with alcohol each night.
-The MA should also check the battery for proper function.
-Glucometers and storage pouches should be labeled with residents' names.

Telephone interview on 12/09/15 at 8:25 am with a representative of the manufacturer of the Brand A glucometers revealed:
-The glucometers were approved for use on multiple residents.
-The manufacturer recommended disinfecting the glucometer using Environmental Protection Agency (EPA) approved "Clorox" disinfecting wipes, which were available from the manufacturer of the glucometer, according to the manufacturer's instructions.
-The glucometer could be disinfected per the guidelines of the CDC and an EPA approved bactericidal, germicidal, and tuberculocidal disinfecting wipe effective against Hepatitis.
-The lancing pen should never be used for more than one resident.

Based on CDC guideline for infection prevention in glucose monitoring, lancing devices (pens) should never be used for more than one individual.

Observation on 12/09/15 at 8:20 am and interview with the ND revealed:
-The ND presented a stock bottle of chemical (TB-Cide-Quat) identified by the ND as the

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disinfectant used by the third shift MA for disinfecting glucometers.
-The product was labeled as an EPA approved Tuberculocidal-Virucidal product.
-Directions for use stated to spray surface until covered in solution, allow product to penetrate and the surface to remain wet for 3 minutes (for bloodborne pathogens). Allow surface to remain wet for Hepatitis B and C viruses for 5 minutes and tuberculosis for 5 minutes; wipe off with a clean cloth, mop, or sponge.
-The ND stated the residents' glucometers were cleaned by third shift daily with alcohol and "TB-Cide" was used every Friday on third shift to disinfect the glucometers.

A. Review of Resident #3's current FL-2 dated 07/08/15 revealed:
-Diagnoses included type 2 diabetes, and hypertension.
-An order for sliding scale insulin (SSI) before meals. (FSBS checks are required for obtaining FSBS values used for administering SSI).

Review of Resident #3's record revealed signed physician's orders dated 10/31/15 FSBS before meals and SSI before meals.

Observation on 12/08/15 of the black canvas pouch labeled for Resident #3's revealed:
-The pouch contained a Brand A glucometer that was labeled on the back in permanent black marker, but almost faded away, with a different resident's name (Resident #2).
-The glucometer's time and date were not set to current time and date.
-The glucometer's memory documented FSBS values daily.

Review of Resident #3's FSBS values

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documented on the November 2015 and December 2015 electronic Medication Administration Record (eMAR) and the glucometer memory (time and date not set correctly and adjusted accordingly) from 11/19/15 to 12/08/15 revealed:
-The FSBS was documented as completed daily at 8:00 am, 12:00 pm, and 5:00 pm on the eMAR.
-FSBS values were recorded in the glucometer's memory for 3 times a day from 12/04/15 to 12/08/15 with 13 of 15 occasions when the FSBS values documented in glucometer's memory corresponded to FSBS values documented on Resident #3's eMAR from 12/04/15 to 12/08/15.
-From 11/19/15 to 12/04/15, FSBS values were recorded in glucometer's history at either 8:00 am or 8:00 pm only.
-Beginning on 11/19/15 at 8:00 am through 12/04/15 at 8:00 am, 21 of 21 values documented in the glucometer's memory did not corresponded to values documented on Resident #3's eMARs.

Review of the November 2015 and December 2015 electronic Medication Administration Records (eMARs) for another resident (Resident #2) revealed 21 of 22 FSBS values documented from 11/19/15 to 12/04/15 were consistent with FSBS values recorded in the Brand A glucometer's memory located in Resident #3's pouch but labeled with Resident #2's name.

Examples of FSBS values not documented on Resident #3's November 2015 and December 2015 eMARs but recorded in the memory of the glucometer used to check Resident #3's FSBS beginning on 11/27/15 and ending on 12/04/15 included:
-FSBS 137 on 12/04/15 at 8:00 am, with 134 documented on the eMAR.
-FSBS 136 on 12/03/15 at 8:00 am, with 120

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documented on the eMAR.
-FSBS 114 on 12/02/15 at 8:00 am, with 122 documented on the eMAR.
-FSBS 136 on 11/30/15 at 8:00 am, with 106 documented on the eMAR.
-FSBS 167 on 11/29/15 at 8:00 pm, with no time scheduled on the eMAR.
-FSBS 125 on 11/29/15 at 8:00 am, with 88 documented on the eMAR.
-FSBS 169 on 11/28/15 at 8:00 pm, with no time scheduled on the eMAR.
-FSBS 130 on 11/27/15 at 8:00 pm, with no time scheduled on the eMAR.

Interview on 12/09/15 at 6:10 pm Resident #3 revealed:
-Staff checked his FSBS three times a day.
-Staff were responsible to take his FSBS and he did not pay attention to the glucometer used.

Refer to interview on 12/08/15 at 3:00 pm and 12/09/15 at 10:00 am with first shift MA.

Refer to interviews on 12/08/15 at 4:00 pm and on 12/09/15 at 9:05 am with the Nursing Director (ND).

Refer to interview on 12/09/15 at 8:00 am with a third shift MA.

Refer to interview on 12/09/15 at 11:05 am with second MA for first shift.

Refer to interview on 12/09/15 at 3:30 pm with a second shift MA.

Refer to interview on 12/09/15 at 6:35 pm with the Administrator.

Based on observation and review of FSBS values

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recorded in the glucometers' memories, Resident #3's Brand A glucometer and Resident #2's Brand A glucometer were switched in the residents' storage pouches on 12/04/15.

B. Review of Resident #2's current FL-2 dated 03/11/15 revealed:
-Diagnoses included diabetes, gout, hypertension and Alzheimer's disease.
-An order for fingerstick blood sugar (FSBS) checks before meals and at bedtime.

Review of Resident #2's record revealed signed physician's orders dated 10/20/15 ordering FSBS before meals daily in the morning, and at bedtime.

Observation on 12/08/15 of the black canvas pouch labeled for Resident #2 revealed:
-The pouch contained a Brand A glucometer that was labeled on the back in permanent black marker, but almost faded away, with a different resident's name (Resident #3).
-The glucometer's time and date were set correctly to current time and date.
-The glucometer's memory documented FSBS values daily.

Review of Resident #2's FSBS values documented on the November 2015 and December 2015 electronic Medication Administration Record (eMAR) and the glucometer memory from 11/23/15 to 12/08/15 revealed:
-FSBS were documented as obtained daily at 8:00 am and 8:00 pm daily on the eMAR.
-Three FSBS values were recorded in the glucometer's memory for once a day from 12/04/15 to 12/08/15.
-There were 3 of 3 occasions when the

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documented FSBS values in glucometer's memory corresponded to FSBS values documented on Resident #2's eMAR from 12/04/15 to 12/08/15.
-From 11/22/15 to 12/04/15, FSBS values were recorded in glucometer's history routinely at 7:00 am, 12:00 noon, and 4:30 pm daily.
-Beginning on 11/22/15 at 8:00 am through 12/04/15 at 8:00 am, 37 of 37 values documented in the glucometer's memory did not corresponded to values documented on Resident #2's eMARs.

Examples of FSBS values not documented on Resident #2's eMARs but recorded in the glucometer's memory of the used to check Resident #2's FSBS beginning on 11/27/15 and ending on 12/04/15 included:
-FSBS 171 on 12/01/15 at 4:28 pm, with no time scheduled on the eMAR.
-FSBS 105 on 12/01/15 at 12:01 pm, with no time scheduled on the eMAR.
-FSBS 106 on 11/30/15 at 7:20 am, with 156 documented on the eMAR.
-FSBS 186 on 11/29/15 at 4:42 pm, with no time scheduled on the eMAR.
-FSBS 171 on 11/29/15 at 12:26 pm, with no time scheduled on the eMAR.
-FSBS 88 on 11/29/15 at 6:56 am, with 125 documented on the eMAR.
-FSBS 124 on 11/28/15 at 4:42 pm, with no time scheduled on the eMAR.
-FSBS 84 on 11/28/15 at 11:52 am, with no time scheduled on the eMAR.
-FSBS 148 on 11/28/15 at 7:18 am, with 135 documented on the eMAR.
-FSBS 106 on 11/27/15 at 4:30 pm, with no time scheduled on the eMAR.

Review of the November 2015 and December 2015 eMARs for another resident (Resident #3)

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D932	Continued From page 13 revealed 34 of 37 FSBS values documented, from 11/22/15 to 12/04/15, were consistent with FSBS values recorded in the Brand A glucometer's memory in Resident #2's pouch but labeled with Resident #3's name. Based on observation and record review, Resident #2 was determined to not be interviewable. Refer to interview on 12/08/15 at 3:00 pm and 12/09/15 at 10:00 am with first shift MA. Refer to interviews on 12/08/15 at 4:00 pm and on 12/09/15 at 9:05 am with the Nursing Director (ND). Refer to interview on 12/09/15 at 8:00 am with a third shift MA. Refer to interview on 12/09/15 at 11:05 am with second MA for first shift. Refer to interview on 12/09/15 at 3:30 pm with a second shift MA. Refer to interview on 12/09/15 at 6:35 pm with the Administrator. Based on observation and review of FSBS values recorded in the glucometers' memories, Resident #3's Brand A glucometer and Resident #2's Brand A glucometer were switched in the residents' storage pouches on 12/04/15. C. Review of Resident #4's current FL-2 dated 3/17/15 revealed diagnoses included diabetes mellitus, hypertension and dementia. Review of Resident #4's record revealed:	D932		

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D932	Continued From page 14 -A physician's order dated 09/22/15 to check fasting blood sugars every morning. -A subsequent order dated 10/12/15 to decrease morning fingerstick blood sugar (FSBS) checks to 3 times a week on Monday, Wednesday, and Friday. Observation on 12/08/15 of the black canvas pouch labeled for Resident #4's revealed: -One of the labeled black canvas contained a Brand A glucometer, labeled with Resident #4's name, test strips, and, a reusable lancing device (unlabeled for resident's name) but not lancets for the pen. -The glucometer's time and date were set correctly to current time and date. -The glucometer's memory had sporadic FSBS values documented. -FSBS values were recorded in the glucometer's memory various days and times from 06/24/15 at 9:46 am (164) and 3:58 pm (132), to 12/07/15 at 7:02 am (154). Review of Resident #4's FSBS values documented on the November 2015 and December 2015 electronic Medication Administration Record (eMAR) and the glucometer's memory from 11/01/15 to 12/08/15 revealed: -The FSBS was documented as completed 3 times a week at 8:00 am (Monday, Wednesday, and Friday) on the eMARs. -There were 40 FSBS values recorded from 11/01/15 to 12/07/15. -FSBS values were recorded in the glucometer's memory for 3 times a week from 11/09/15 to 12/07/15 with 13 of 15 values in the glucometer's memory corresponding to FSBS documented on Resident #4's eMARs from 12/07/15 to 11/09/15. -There were 2 FSBS values in glucometer's	D932		

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memory documented for Sunday, 11/22/15 (FSBS of 131 at 7:30 am and FSBS of 114 at 12:43 pm) that did not correspond to FSBS values documented on Resident #4's November 2015 eMAR.
(The FSBS values corresponded to FSBS values documented on Resident #2 and #3 respectively with no FSBS value recorded in the residents ' glucometers memory to correspond.)
-Twenty-five FSBS values were documented in the glucometer's memory with none of the FSBS values corresponding to values documented on Resident #4's eMARs from 11/01/15 at 1:24 pm to 11/08/15 at 12:24 pm.
-Twenty of the FSBSs documented on Resident #4's eMARs from 11/01/15 at 1:24 pm to 11/08/15 at 12:24 pm corresponded to FSBS values documented on Resident #3's November 2015 eMAR with none of the FSBS values recorded in Resident #3's glucometer's memory.

Examples of FSBS values recorded in Resident #4's Brand A glucometer and not corresponding to Resident #4's November 2015 eMAR included:
-FSBS 97 on 11/08/15 at 7:00 am..
-FSBS 102 on 11/07/15 at 7:22 am.
-FSBS 111 on 11/07/15 at 12:26 pm.
-FSBS 155 on 11/07/15 at 4:35 pm.
-FSBS 122 on 11/05/15 at 6:54 am.
-FSBS 139 on 11/05/15 at 12:19 pm.
-FSBS 134 on 11/05/15 at 5:02 pm.
-FSBS 94 on 11/02/15 at 6:48 am.
-FSBS 118 on 11/02/15 at 11:29 am.
-FSBS 168 on 11/02/15 at 5:04 pm.
-FSBS 127 on 11/02/15 at 8:55 pm.

Continued review of the Brand A glucometer labeled for Resident #4 revealed FSBS values recorded in the glucometer's memory beginning on 06/24/15 at 9:46 am.

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D932	Continued From page 16 Based on record review, and observation on 12/09/15, Resident #4 was unable to provide reliable information. Interview on 12/09/15 at 9:05 am with the ND revealed: -Resident #4 just recently was ordered FSBS. -Resident #4 should have been assigned a new glucometer when the resident started FSBS checks. -She was not aware how the lancing pen remained in the resident's storage pouch. -Staff were not supposed to be using lancing pens. -She did not think the facility had ordered lancets for pens because the facility routinely used single use disposable lancing devices. Interview on 12/09/15 at 10:00 am with first shift MA revealed: -She remembered when Resident #4 started receiving FSBS check. -She thought Resident #4 received a new glucometer because she recalled it was in the manufacturer's box along with a lancing pen and a small supply of lancets for the pen. -She did not recall using the lancing pen to obtain a FSBS. -She stated she was aware Resident #4 had a lancing pen still in the storage pouch. Interview on 12/09/15 at 11:05 am with second MA for first shift revealed she had not used a lancing pen to obtain blood for FSBS in more than 3 years. Interview on 12/09/15 at 3:30 pm with a second shift MA revealed she had never used a lancing pen for obtaining FSBS for a resident.	D932		

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D932	Continued From page 17 Refer to interview on 12/08/15 at 3:00 pm and 12/09/15 at 10:00 am with first shift MA. Refer to interviews on 12/08/15 at 4:00 pm and on 12/09/15 at 9:05 am with the Nursing Director (ND). Refer to interview on 12/09/15 at 8:00 am with a third shift MA. Refer to interview on 12/09/15 at 11:05 am with second MA for first shift. Refer to interview on 12/09/15 at 3:30 pm with a second shift MA. Refer to interview on 12/09/15 at 6:35 pm with the Administrator. Based on observation of an unassigned lancing pen in the black canvas storage case with visible blood residue and FSBS values documented in the glucometer labeled for Resident #4 that were documented prior to Resident #4 being assigned the glucometer, it could not be determined if the lancing pen was used for Resident #4. _____ Interview on 12/08/15 at 3:00 pm and 12/09/15 at 10:00 am with first shift MA revealed: -She worked first shift and was responsible for obtaining FSBS checks after 9:00 am and before 3:00 pm. -Third shift MAs checked FSBSs ordered in the mornings. -She was not aware of the procedure to label the glucometer and the storage pouch. -She stated the facility procedure was each resident had a glucometer assigned to the resident and staff were supposed to use the	D932		

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assigned glucometer only for the assigned resident FSBS.
-She was not aware of an occasion when she had knowingly used an assigned glucometer to check a different resident's FSBS.
-She routinely wiped the glucometer after each use with an alcohol wipe to clean.
-She stated she did not compare the name on the glucometer to the name on the storage pouch before obtaining FSBS values for a resident.
--She routinely used the glucometer stored in the pouch labeled with the resident's name to check a resident's FSBS.
-She had no idea when the glucometers could have been switched.
-She was aware the facility had another product that third shift MA used to clean the glucometers, but she did not use any product other than alcohol to wipe the glucometers.

Interviews on 12/08/15 at 4:00 pm and on 12/09/15 at 9:05 am with the Nursing Director (ND) revealed:
-She was unable to provide a written policy for FSBS monitoring and glucometer usage.
-Staff had received training in glucometer usage within the last year.
-The facility's procedure was every resident had their own glucometer, "We don't share glucometers."
-"We throw out lancing pens."
-The facility procedure was to label glucometers and storage pouches.
-The facility always had one glucometer in backup that could be assigned to a resident if needed.
-When the back-up glucometer is used another is ordered from the pharmacy provider to replace the glucometer.
-The glucometer should not be re-used on a

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different resident after being assigned to a resident.
-Staff were supposed to routinely verify residents' names on both the storage pouch and glucometer before taking FSBS.
-She was not aware if the glucometer (Brand A) was approved for use on multiple residents because the facility does not use for more than one resident.
-She instructed Medication Aides to use alcohol wipes to clean the glucometers daily and "TB-Cide" weekly to clean the glucometers according to the instructions on the label of the disinfectant.
-She did not have a system in place to routinely monitoring residents' glucometers use including comparing readings documented on the residents' eMARs to values in their assigned glucometers' memories or checking to see if assigned glucometers were stored in the correct storage pouches.

Interview on 12/09/15 at 8:00 am with a third shift MA revealed:
-She was responsible to order diabetic supplies for residents; like strips, single use disposable lancing devices, and glucometers with physician's orders.
-She was responsible to clean the glucometers for the 4 residents daily with alcohol wipes as instructed by the Nursing Director.
-She stated that weekly she was responsible to routinely clean the glucometers with another product "TB-Cide".
-She stated she donned gloves, wet a wash cloth with "TB-Cide", wiped the glucometer with the wash cloth saturated with "TB-Cide", wiped the glucometer with another wash cloth dampened with water (for a rinse), and use another cloth to dry the glucometer before placing the glucometer

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in the case for use.
-The entire process took 2 to 3 minutes from start to finish but she did not time the process.
-She had not reviewed the disinfecting instructions on the bottle of "TB-Cide" that instructed the item being disinfected should remain visibly wet for 3 to 5 minutes before drying to be effective.
-She did not keep a log for cleaning and disinfecting residents' glucometers.

Interview on 12/09/15 at 11:05 am with second MA for first shift revealed:
-She routinely performed one finger stick at a time, and finished before doing another FSBS.
-Glucometers at the facility were supposed to be labeled with residents' names along with the storage pouch.
-Staff were trained to compare the resident's name on the glucometer and the pouch before obtaining FSBS.
-She stated she may not always check the name on the glucometer but always used the glucometer in the storage pouch for the resident receiving the FSBS.
-She repeated the facility policy for not sharing residents' glucometers.
-Residents' glucometer were routinely assigned by the third shift MA.
-She stated she routinely cleaned the glucometer after each use with alcohol but had used a water soaked paper towel if visible soiled, and then alcohol.
-She had never disinfected a glucometer with "TB-Cide" because it was assigned to one resident.
-She was not aware how residents' glucometers could get in the wrong storage pouches.

Interview on 12/09/15 at 3:30 pm with a second

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D932	Continued From page 21 shift MA revealed: -She did not routinely disinfect glucometers. -She had used "TB-Cide" to disinfect residents' glucometer before as follows: dampen a cloth with" TB-Cide", wiped the glucometer, and the inside of the storage pouch let the glucometer and pouch air dry and returned the glucometer to the pouch. - She stated she did not saturate the glucometer until wet before allowing to air dry. -She did not routinely compare the name on the glucometer to the name on the storage pouch for match. -She stated she was not aware of a time when she knowingly shared a glucometer between 2 residents. Interview on 12/09/15 at 6:35 pm with the Administrator revealed the Nurse Director (ND) was responsible for monitoring the Medications Aides and overseeing the use of glucometers and infection prevention. On 12/09/15, the Nurse Director submitted a Plan of Protection as follows: -The current glucometers were removed from the facility. -New glucometers were purchased and assigned to residents. -The glucometers would be engraved with the resident's name and stored in individual boxes. -All medication aides would be inserviced prior to their next scheduled shift regarding infection control procedures and glucometer use. -The glucometers would be monitored and staff inserviced on a regular basis. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 23, 2016.	D932		

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