STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060019	A. BUILDING: _____ B. WING _____	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF CHARLOTTE	6000 PARK SOUTH DRIVE CHARLOTTE, NC 28210

(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 Mecklenburg County Department of Social Services conducted an annual survey on January 9 - 12, 2018.	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: Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 3 of 4 sampled residents (Residents #3, #6, and #11) with physician orders for mechanical soft (MS) and consistent carbohydrate diets (CCHO). The findings are: A. Review of Resident #11's current FL2 dated 8/16/17 revealed: -Diagnoses included obstructive sleep apnea, essential tremor and gastroesophageal reflux disease (GERD). -There was a physician's order for a No Added Salt (NAS) diet. Review of Resident #11's Physician Order Summary Report dated 12/6/17 revealed a subsequent physician's order for a NAS mechanical soft texture diet.	D 310		

Reviewed and accepted with revisions on 4/23/18 by Jennifer Fender/JF

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D 310	Continued From page 1 Review of the therapeutic diet list posted in the kitchen dated 1/2/18 revealed Resident #11 was to be served a NAS MS diet. Review of the Fall/Winter 2018 therapeutic diet spreadsheet for lunch on 1/10/18 revealed residents on a MS diet were to be served: -Teriyaki chicken ground, brown rice, stir fried vegetables, crustless bread, canned fruit. -The alternate choices included pureed vegetable beef soup and ice cream. -No crackers. Observation on 1/10/18 from 11:30 am to 1:05 pm of the lunch meal service in the Assisted Living (AL) dining room revealed: -Computer generated menus were used by each of the residents to place their order. -2 dietary servers were writing orders on individual meal tickets as each resident placed their order. -Resident #11 was served ground chicken, chopped stir fried vegetables, brown rice, sugar free Jello and water. -Resident #11 was also served a chopped fried egg roll with a hard crust, vegetable beef soup with chunks of beef and vegetables that were not pureed and 2 packs of crackers on the side not buttered and not softened in liquid. -Resident #11 ate without difficulty and consumed 100% of her meal. Interview on 1/10/18 at 1:05 pm with the 2 dietary servers who served lunch in the AL dining room revealed: -Neither had served Resident #11 crackers for lunch. -They were unaware she had been served crackers. -One of the personal care aides (PCA) must have	D 310		

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D 310	Continued From page 2 served the crackers to Resident #11. -They were unaware residents on a MS diet should have their vegetable beef soup pureed. Interview on 1/10/18 at 1:10 pm with the Dining Services Coordinator revealed: -He was responsible for the overall operations of the food service department. -Therapeutic diet menus were available for menu items created by their corporate office which included the appetizers, main courses, the "community selections" and desserts. -Dining Services Coordinators in each of their facilities created their own additional entrees and these were not included on the therapeutic diet spreadsheet nor reviewed by the Registered Dietitian (RD) for appropriateness. -There was no therapeutic diet menu for the fried egg rolls, but he thought serving it to Resident #11 was "ok since we chopped it up." -He had "not noticed" the therapeutic diet spreadsheet indicated the vegetable beef soup should be pureed for residents on a MS diet. -He did not know Resident #11 had been served crackers. Interview on 1/12/18 at 10:35 am with Resident #11 revealed: -She was on a MS diet. -She was unsure why she was on a MS diet but had speech therapy in the past due to problems with swallowing. -She had no recent episodes of choking. -She had no problem eating the crackers, fried egg roll, or vegetable beef soup. Telephone interview on 1/11/18 at 11:12 am with the Vice President of Menu Development revealed: -She was the Registered Dietitian (RD) who	D 310		

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D 310	Continued From page 3 approved the therapeutic menus for the facility. -The facility's corporate office created the therapeutic menus and she reviewed them for accuracy. -Residents on a MS diet could have crackers as long as they were buttered or softened in liquid such as soup. -Residents on a MS diet should have the vegetable beef soup pureed due to it containing large pieces that were difficult to swallow. -Because the egg roll was fried and contained a crust, it could cause a problem with swallowing for residents on a MS diet. -Serving foods not allowed on the MS diet could cause a resident to choke and aspirate. Telephone interview on 1/11/18 at 12:10 pm with the primary care provider (PCP) for Resident #11 revealed: -Resident #11 was on a MS diet. -He could not recall why she was on a MS diet but knew she had "several gastrointestinal issues." -He expected the facility to serve diets as ordered. -There was potential for residents choking and aspirating if served foods not allowed on the MS diet. Refer to interview on 1/10/18 at 8:30 am with a dietary server in the AL dining room. Refer to interview on 1/11/18 at 12:35 pm with the Executive Director. B. Review of Resident #6's current FL2 dated 7/17/17 revealed: -Diagnoses included Alzheimer's dementia, diabetes mellitus and elevated triglycerides/lipids. -There was a physician's order for a Consistent	D 310		

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D 310	Continued From page 4 Carbohydrate (CCHO) diet. Review of the therapeutic diet list posted in the kitchen dated 1/2/18 revealed Resident #6 was to be served a CCHO diet. Review of the Fall/Winter 2018 therapeutic diet spreadsheet for breakfast on 1/10/18 revealed residents on a CCHO diet were to be served: -1/2 cup (c.) fresh fruit, their choice of ¾ c. cold cereal or ½ c. oatmeal with sugar substitute and 1 tablespoon (tbsp.) raisins, ½ c. hash browns, 1 egg of their choice or 1 omelet, 1 slice bacon or 1 sausage link, 1 slice toast, 1 margarine, 1 diet jelly, 1 c. sugar free beverage, ¾ c. coffee or tea, 1 c. milk, 1 sugar substitute and 1 creamer. -No brown sugar and no orange juice. Observation on 1/10/18 from 8:10 am to 9:15 am of the breakfast meal service in the Special Care Unit (SCU) dining room revealed: -Resident #6 was served 1 carbohydrate controlled nutritional supplement, 1 slice toast, 2 slices bacon, scrambled eggs, water and milk. -Resident #6 was also served oatmeal with brown sugar instead of a sugar substitute and orange juice instead of a sugar free beverage. -Resident #6 ate 100% of his meal and drank 100% of his orange juice, 100% of his water and none of his milk. Review of the Fall/Winter 2018 therapeutic diet spreadsheet for the afternoon snack on 1/10/18 revealed residents on a CCHO diet were to be served a snack of their choice and a sugar free beverage. Observation on 1/10/18 at 4:05 pm of the snack service in the SCU living room revealed: -Resident #6 was served popcorn and cranberry	D 310		

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D 310	Continued From page 5 juice for a snack. -Glasses containing cranberry juice were on a tray for all residents in the SCU. -The glasses were the same and there was no sugar free beverage available for Resident #6. Interview on 1/10/18 at 1:05 pm with the Dining Services Coordinator revealed: -He was responsible for the overall operations of the food service department. -Food was prepared in the main kitchen, transported in a hot box to the SCU and served from a heated table. -Personal care aides (PCA) were responsible for plating the food and serving it to the residents. -He worked in the SCU serving kitchen during a breakfast meal service and a dinner meal service each week to ensure the PCAs were serving appropriate foods according to the residents' physician ordered diets. -The PCAs were to use a notebook containing photos of how foods should be served and the therapeutic diet spreadsheets for reference when serving. Interview on 1/11/18 at 8:50 am with a SCU PCA revealed: -She was the staff person plating food during the breakfast meal service on 01/10/18. -She was aware of what diet each resident was on because she referred to the list posted in the SCU kitchen. -Therapeutic menu spreadsheets were available in the SCU serving kitchen so staff knew which foods were allowed on each diet. -She had been employed with the facility for 2 years and was familiar with the diets so she did not use the therapeutic menu spreadsheets for reference. -She had plated Resident #6's breakfast and had	D 310		

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D 310	Continued From page 6 added brown sugar to his oatmeal. -Another PCA had served regular juice to Resident #6. -It was her responsibility to ensure each resident was served only what was allowed on their diet. -She was aware residents on a CCHO diet should not be served brown sugar or juice. -She "made a mistake" and did not provide the server with a CCHO plate for Resident #6 and failed to tell the server that he required a sugar free beverage. Telephone interview on 1/12/18 at 1:35 pm with the Licensed Practical Nurse (LPN) at Resident #6's PCP's office revealed: -Resident #6's blood sugars were normal, so getting brown sugar, orange juice and cranberry juice was "ok." -"They (the facility) should not make it a habit to serve these items." Interview on 1/11/18 at 12:35 pm with the Executive Director revealed: -She expected SCU staff to refer to the therapeutic menu spreadsheet when serving residents. -She expected staff to serve only what was allowed on each resident's diet. -She planned to retrain all staff on dietary procedures. Based on record review and observation, it was determined Resident #6 was not interviewable. Attempted telephone interview on 1/12/18 at 10:10 am with Resident #6's guardian was unsuccessful. C. Review of Resident #3's current FL2 dated 11/28/17 revealed:	D 310		

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D 310	Continued From page 7 -Diagnoses included closed compression fracture of lumbar spine, L1; dysphagia; gerd; acute respiratory failure; pulmonary embolism. -The Resident's diet order was documented as Regular, Thickened liquids. Review of Resident #3's physician orders dated 12/1/17 revealed a dietary order for Regular Mechanical Soft (MS), with Nectar Thickened Liquids. Review of the therapeutic diet list posted in the kitchen dated 1/02/18 revealed Resident #3 was to be served a regular, Mechanical Soft textured diet with nectar thickened liquids. Review of the Fall/Winter 2018 therapeutic diet spreadsheet for breakfast on 1/10/18 revealed residents on a MS diet were to be served: -Canned fruit, cold cereal of their choice, oatmeal with brown sugar, egg of their choice, ground omelet, ground sausage link with cream gravy, and crustless bread. -No raisins or bacon. Observation on 1/10/18 from 7:30 am to 10:00 am of the breakfast meal service revealed: -Resident #3 was served cold cereal with nectar thickened milk and sliced bananas, a scrambled egg, 1 slice of raisin toast with crust, 2 slices of bacon and tomato juice, nectar thickened consistency. -Resident #3 ate 100% of her cereal, 100% of her bacon and drank 100% of her tomato juice without difficulty and ate none of her raisin toast or scrambled egg. Review of the Fall/Winter 2018 therapeutic diet spreadsheet for lunch on 1/10/18 revealed residents on a MS diet were to be served:	D 310		

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D 310	Continued From page 8 -Teriyaki chicken ground, brown rice, stir fried vegetables, crustless bread and canned fruit. -The alternate choices included pureed vegetable beef soup and ice cream. -No crackers. Observation on 1/10/18 from 11:30 am to 1:05 pm of the lunch meal service revealed: -Resident #3 was served a grilled pimento cheese sandwich, potato chips, pineapple chunks with coconut, ice cream and nectar thickened tea. -Resident #3 ate 25% of her grilled pimento cheese sandwich, 100% of her potato chips, 50% of the pineapple chunks with coconut, a few bites of ice cream and drank 75% of her nectar thickened tea without difficulty. Interview on 1/10/18 at 12:00 pm with a personal care aide (PCA) on Resident #3's floor revealed: -"Resident had been on a Regular diet for about a month or so." -Resident was independent with feeding. -PCA was not aware of any swallowing or choking incidents with meals. Interview on 1/10/18 at 1:05 pm with 2 Dietary Servers revealed: -Resident #3's diet order had changed from a MS diet to a regular diet 2 weeks prior. -Dietary staff had been notified by another staff member that the diet for Resident #3 had changed to a regular diet. -They were unable to recall which staff member had verbalized the change to them. -They had served Resident #3 a regular diet since being told of the change. -They were aware Resident #3 was still listed on the therapeutic diet list as being on a MS diet. -They were aware that residents on a MS diet should not be served bacon, raisin toast and	D 310		

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D 310	Continued From page 9 potato chips but had served these items to Resident #3 because they thought she was on a regular diet. Interview on 1/10/18 at 1:10 pm with the Dining Services Coordinator revealed: -When nursing received a new diet order, they would put a copy of it in his staff box. -He was responsible for creating the therapeutic diet list based on the physician's orders placed in his staff box. -He had not received a diet order indicating Resident #3's diet had been changed from MS to regular. -He was unaware the dietary servers were serving a regular diet to Resident #3. -He expected the dietary servers to refer to the therapeutic diet list when serving residents. -Therapeutic diet menus were available for menu items created by their corporate office which included the appetizers, main courses, the "community selections" and desserts. -Dining Services Coordinators in each of their facilities created their own additional entrees and these were not included on the therapeutic diet spreadsheet. -There was no therapeutic diet menu for the grilled pimento cheese sandwich or potato chips. Interview on 1/11/18 at 10:24 am with Resident #3 revealed: -She believed her diet was regular and was changed sometime in the past month. -She did not know why her diet (MS) changed or who changed it. -She had no difficulty eating the regular diet. Interview on 1/11/18 at 10:45 am with the Wellness Nurse revealed: -She and the other Wellness Nurses were	D 310		

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D 310	Continued From page 10 responsible for processing new diet orders. -When a new diet order or diet order change was received from the physician, they would fax it to the pharmacy and add a communication note to the internal computer system. -Each care staff had their own account and could access the communication notes at any of the kiosks. -The notes would generally remain active for 1 week, or longer if they wanted to extend the expiration date. -The Wellness Nurses were also responsible for putting a copy of the diet order in the staff box of the Dining Services Coordinator. -Resident #3's diet order was still MS with nectar thickened liquids and no changes had been made. Interview on 1/11/18 at 11:00 am with Resident #3's family member revealed: -He called Resident #3's primary care provider (PCP) after her hospital discharge (11/30/17) regarding Resident #3 diet. -He left a message requesting Resident #3's diet to be changed from Mechanical Soft to Regular diet. -Shortly after that phone call, dietary staff began serving Resident #3 a regular diet, continuing nectar thickened liquids. -He did not hear back from the PCP regarding diet change. -He did not tell dietary staff that Resident #3's diet had changed to regular; he assumed they had received an order from the PCP. - Resident #3 enjoyed her regular diet and had no difficulty eating a regular diet. Telephone interview on 1/11/18 at 11:12 am with the Vice President of Menu Development revealed:	D 310		

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D 310	Continued From page 11 -She was the Registered Dietitian (RD) who approved the therapeutic menus for the facility. -Residents on a MS diet should not be served potato chips or bacon. -Residents on a MS diet should not be served raisin bread due to raisins being difficult to swallow. -Serving foods not allowed on the MS diet could cause a resident to choke and aspirate. Telephone interview on 1/11/18 at 12:10 pm with the PCP for Resident #3 revealed: -Resident #3 was on a MS diet due to a history of dysphagia. -He had not changed her diet to regular. -He was unaware of any other provider changing her diet to regular. -He expected the facility to serve diets as ordered. -There was a potential for residents to choke and/or aspirate if MS diet was not followed as ordered. Refer to interview on 1/10/18 at 8:30 am with a dietary server in the AL dining room. Refer to interview on 1/11/18 at 12:35 pm with the Executive Director. --- Interview on 1/10/18 at 8:30 am with a dietary server in the AL dining room revealed: -He had been employed with this facility for 15 years. -He worked during the breakfast and lunch meal services. -He was responsible for taking orders and serving the residents' meals. -The Cook was responsible for plating food based on what the dietary servers wrote on each	D 310		

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D 310	Continued From page 12 resident's meal ticket. -The dietary servers were responsible for double checking that the food on the plate was appropriate for the resident's diet. -He referred to the therapeutic diet list posted in the kitchen and the therapeutic diet spreadsheet to know what diet each resident was ordered and what foods were allowed on their diet. -If a resident ordered food not allowed on their diet, he would have the Dining Services Coordinator speak with the resident. Interview on 1/11/18 at 12:35 pm with the Executive Director revealed: -The Dining Services Coordinator was responsible for compiling a list of residents and their physician ordered diets. -She expected staff to refer to the therapeutic diet list posted by the Dining Services Coordinator when serving residents. -Staff should not rely on verbal information provided by other staff, residents or residents' family members regarding diet changes. -She expected staff to refer to the therapeutic menu spreadsheet when serving residents. -She expected staff to serve only what was allowed on each resident's diet. -In addition to dietary staff, 2 PCAs were assigned to work in the AL dining room each day during the lunch meal service. -The PCAs received the same training as all other dietary staff. -She discovered today staff were writing only the resident's room number on meal order tickets and not their names. -The cook was not familiar with resident room numbers so he did not know which diet to plate. -She planned to retrain all staff on dietary procedures. -She would ensure servers wrote both the room	D 310		

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D 310	Continued From page 13 number and the resident's name on the meal order tickets so the cook would know what foods were appropriate to plate. -She would ensure the therapeutic diet list would have both the room number and resident's name.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's primary care provider (PCP) for clarification of orders for medications for 1 of 7 sampled residents (Resident #6) regarding an order for Lantus insulin with parameters for finger stick blood sugars (FSBS). The findings are: Review of Resident #6's current FL2 dated 7/7/17 revealed: -Diagnoses included Alzheimer's dementia and	D 344		

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D 344	Continued From page 14 diabetes. -An order for Lantus insulin (a long acting injectable medication used to lower blood sugar) inject 5 units subcutaneously (SQ) at bedtime. Review of Resident #6's Order Summary Report dated 12/2/17 revealed: -A physician order for Lantus insulin 100units/ml inject 5 units SQ at bedtime related to "diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy, hold insulin for (blood glucose) BG<100, call MD for BG>400." -A physician order for blood sugar checks in the morning daily before breakfast. -There was no accompanying order for FSBS at bedtime. Review of the November 2017, December 2017, and January 2018 electronic Medication Administration Records (eMARs) for Resident #6 revealed: -There was an entry for Lantus insulin inject 5 units SQ at bedtime related to "diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy, hold insulin for (blood glucose) BG<100, call MD for BG>400." -There was no entry for FSBS checks prior to the administration Lantus insulin 5 units SQ at bedtime. -There was an entry for FSBS checks daily at 7:00 am. -FSBS results ranged from 79 to 179 from 11/1/17 to 1/10/18. Interview on 1/10/18 at 5:30 pm with the Executive Director (ED) and Resident Care Director (RCD) revealed: -They thought the order for Lantus insulin had	D 344		

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D 344	Continued From page 15 been changed to include FSBS checks prior to administration of Lantus insulin at bedtime. -They would check the order and clarify with the primary care provider (PCP). Telephone interview on 1/12/18 at 9:50 am with a medication aide (MA) revealed she always checked Resident #6's FSBS in the morning. Interview on 1/12/18 at 12:40 pm with a MA in the Special Care Unit (SCU) revealed: -FSBS should be checked if there are parameters on the eMAR. -FSBS had not been checked prior to administration of the 8:00 pm Lantus insulin dose. Interview on 1/12/18 at 1:35 pm with Resident #6's PCP's Licensed Practical Nurse revealed she expected staff to check blood sugars prior to administration of the 8 pm dose of Lantus insulin. Interview on 1/12/18 at 11:15 am with the ED revealed: -The Wellness Nurse was responsible for reviewing and making changes to the eMARs. -There had been no chart audits done since June 2017. Based on observations and record review, it was determined Resident #6 was not interviewable. Attempted telephone interview with Resident #6's power of attorney on 1/12/18 at 10:10 am was unsuccessful by exit.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 16 (a) An adult 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer a diabetic (Starlix) medication as ordered for 1 of 7 residents (#6) observed during the medication pass, and 1 of 7 sampled residents (#6) regarding an order for Lantus insulin with parameters for finger stick blood sugars (FSBS). The findings are: Review of Resident #6's current FL2 dated 7/7/17 revealed diagnoses included Alzheimer's dementia, and diabetes. Review of Resident #6's Resident Register revealed the resident was admitted to the facility 7/12/11. A. Review of Resident #6's current FL2 dated 7/7/17 revealed an order for Starlix (nateglinide) 60 mg. (Starlix is an oral medication used to lower blood sugar in diabetics.) Review of Resident #6's record revealed subsequent signed physician orders dated 12/21/17 for nateglinide 60 mg "one tablet before	D 358		

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D 358	Continued From page 17 meals related to diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy. Take one tablet every 8 hours, 30 minutes prior to meals, hold if NPO (nothing by mouth) or poor by mouth intake." Observation of medication administration during the medication pass on 1/10/18 at 10:40 am revealed the medication aide (MA) in the Special Care Unit (SCU) prepared and administered one Starlix (nateglinide) 60 mg tablet to Resident #6 (residing in the SCU). Interview on 1/10/18 at 10:45 am with the MA in the SCU revealed: -She did not routinely administer medications in the SCU. -Medications appeared on the electronic Medication Administration Record (eMAR) computer monitor one hour before and stayed up one hour after the scheduled time for administration. -Resident #6 walked around a lot so MA staff had to catch him as he was walking by the medication room. -She stated the residents in the SCU ate lunch at 11:30 am. Observation of the lunch meal on 1/10/18 in the Special Care Unit revealed Resident #6 was served the lunch meal at 12:10 pm. Review of the manufacturer's guideline for the administration of nateglinide revealed: -The manufacturer recommended administering one to 30 minutes before a meal. -The manufacturer alerts for "Hypoglycemia: STARLIX may cause hypoglycemia. Administer before meals to reduce the risk of hypoglycemia. Skip the scheduled dose of STARLIX if a meal is	D 358		

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D 358	Continued From page 18 skipped to reduce the risk of hypoglycemia." Telephone interview on 1/11/18 at 9:20 am with the MA in the SCU (that administered the Starlix on 1/10/18) revealed: -She was floater MA meaning she worked the SCU and the Assisted Living Unit, depending on which MA she filled in for on a given day. -She worked the SCU 2 or 3 times a week. -The Resident Care Director (RCD) or nurses would be who she expected to inform or train her of any special administration instructions for a medication. -She chose to administer Resident #6's nateglinide at 10:45 am because that was a time between activities and before everybody started being moved to the dining area (She did not administer medications in the dining area), and Resident #6 was easier to get focused on taking his medication. -She was trained on the medication cart by the previous RCD and a former MA that worked mainly in the SCU. -She overlooked the special warnings on the eMAR screen and focused on administering the medications according to the time the medications appeared on the eMAR screen. -She was not familiar and had not been trained on the manufacturer's precautions specific to administration of nateglinide. -She did not know why the medication was scheduled so that it would start appearing on the eMAR at 10:00 am if it should not be administered until just before Resident #6 ate lunch at 12:00 pm (Noon). -She would make sure she administered the medication just before Resident #6 ate since she had been made aware of the need. Observation on 1/10/18 at 3:45 pm revealed	D 358		

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D 358	Continued From page 19 Resident #6 was walking from the hallway into the SCU living room. Interview on 1/10/18 at 4:10 pm with the MA in the SCU revealed she did not have any medications to administer for Resident #6 before dinner. Review of Resident #6's January 2018 eMAR, that was printed on 1/10/18 at 4:15 pm revealed: -Nateglinide was scheduled at 7:00 am, 11:00 am, and 4:00 pm daily. -Resident #6 had already received the nateglinide that was due 30 minutes before dinner. -Resident #6's FSBS was 113 on 1/10/18 at 7:00 am. A second interview on 1/10/18 at 5:10 pm with the MA in the SCU revealed: -She had administered the nateglinide "at 3 something" to Resident #6. -The medication was scheduled on the eMAR for 4:00 pm and she stated she had between 3:00 pm and 4:00 pm to give it. Observation on 1/10/18 in the SCU dining room revealed Resident #6 was served his dinner meal at 5:15 pm and consumed 100% of his meal. Interview on 1/11/18 at 4:30 pm with the RCD revealed: -She had entered new administration times of 7:30 am, 11:30 am and 4:43 pm for Resident #6's nateglinide. -She informed the MAs of the new times and that the medication should not be administered before these times. Interview on 1/12/18 at 1:35 pm with Resident #6's PCP's Licensed Practical Nurse (LPN)	D 358		

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D 358	Continued From page 20 revealed the nateglinide should be administered no more than 1 hour before meals. Refer to interview on 1/12/8 at 11:15 am with the ED. Based on observations and record review, it was determined Resident #6 was not interviewable. Refer to attempted telephone interview with Resident #6's power of attorney on 1/12/18 at 10:10 am. B. Review of Resident #6's current FL2 dated 7/7/17 revealed an order for Lantus insulin (an injectable medication used to lower blood sugar) inject 5 units subcutaneously (SQ) at bedtime. Review of Resident #6's Order Summary Report dated 12/2/17 revealed: -A physician order for Lantus insulin 100 units/ml inject 5 units SQ at bedtime related to "diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy, hold insulin for (blood glucose) BG<100, call MD for BG>400." -A physician order for blood sugar checks in the morning daily before breakfast. -There was no accompanying order for FSBS at bedtime. Review of the November 2017, December 2017, and January 2018 eMARs for Resident #6 revealed: -There was an entry for Lantus insulin inject 5 units SQ at bedtime related to "diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy, hold insulin for (blood glucose) BG<100, call MD for BG>400."	D 358		

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D 358	Continued From page 21 -There was no entry for FSBS checks prior to the administration of Lantus insulin 5 units SQ at bedtime. -There was an entry for FSBS checks daily at 7:00 am. -FSBS results ranged from 79 to 179 from 11/1/17 to 1/10/18. Interview on 1/10/18 at 5:30 pm with the Executive Director (ED) and Resident Care Director (RCD) revealed: -They thought the order for Lantus insulin had been changed to include FSBS checks prior to the administration of Lantus insulin at bedtime. -They would check the order and clarify with the PCP. Interview on 1/12/18 at 12:40 pm with the MA in the Special Care Unit (SCU) revealed: -FSBS should be checked if there are parameters on the eMAR. -FSBS had never been checked prior to administration of the 8 pm Lantus insulin dose. Telephone interview on 1/12/18 at 1:12 pm with the PCP's office assistant revealed: -A new order to check FSBS at 8:00 am and prior to the bedtime dose of Lantus insulin was being faxed to the facility today. -The new order contained the same parameters for administration of Lantus insulin at bedtime. Interview on 1/12/18 at 1:35 pm with Resident #6's PCP's LPN revealed she expected staff to check blood sugars prior to administration of the 8:00 pm dose of Lantus insulin. Refer to interview on 1/12/8 at 11:15 am with the ED .	D 358		

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D 358	Continued From page 22 Based on observations and record review, it was determined Resident #6 was not interviewable. Refer to attempted telephone interview with Resident #6's power of attorney on 1/12/18 at 10:10 am. --- Interview on 1/12/8 at 11:15 am with the ED revealed: -The Wellness Nurse was responsible for reviewing and making changes to the eMARs. -There had been no chart audits done since June 2017. Attempted telephone interview with Resident #6's power of attorney on 1/12/18 at 10:10 am was unsuccessful by exit. --- The facility's failure to administer medications as ordered to Resident #6 related to administering an oral diabetic medication (nateglinide) according to the instructions on the eMAR and manufacturer's recommendations, placed the resident at increased risk for hypoglycemia (low blood sugar) episodes, including weakness, fatigue, and loss of consciousness. Failure to administer an injectable diabetic medication (Lantus insulin) according to the instructions on the eMAR placed the resident at increased risk for hypoglycemia episodes, including weakness, fatigue, and loss of consciousness. These failures were detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. --- Review of the facility's Plan of Protection dated 1/12/18 revealed:	D 358		

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D 358	Continued From page 23 -Blood sugar checks were immediately added to Resident #6's eMAR. -The resident's primary physician was contacted to clarify the order for blood sugar checks. (Clarification pending at this time). -The nateglinide order was updated in the eMAR system to reflect medication to be given within 30 minutes of each meal with specific delivery times assigned. -The Resident Care Director (RCD) completed training with medication care managers (MAs) regarding updated arders for specific medications and delivery times scheduled. -The Wellness Nurse will conduct random audits monthly on all residents to assure medications are administered correctly; initially weekly audits to be conducted for 4 weeks. -The RCD to conduct an audit of all medications with specific delivery times as well as diabetics with parameters for blood sugar checks to assure "all medications administered as ordered and on the eMAR correctly." -The RCD will complete quarterly medication pass observations with all MA to ensure delivery compliance. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2018.	D 358		
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.	D912		

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D912	Continued From page 24 This Rule is not met as evidenced by: 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, related to Medication Administration and Adult Care Home Infection Prevention Requirements. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to administer a diabetic (Starlix) medication as ordered for 1 of 7 residents (#6) observed during the medication pass, and 1 of 7 sampled residents (#6) regarding an order for Lantus insulin with parameters for finger stick blood sugars (FSBS). [(Refer to TAG 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).] B. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 4 diabetic residents sampled (#8, 9, and #10) with orders for blood sugar monitoring resulting in the shared use of glucometers. (Refer to Tag D 932, G.S. 131-D 4.4(A)(b) Adult Care Home Infection Prevention Requirements (Type B Violation).]	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection	D932		

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D932	Continued From page 25 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 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.	D932		

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D932	Continued From page 26	D932		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 4 diabetic residents sampled (#8, 9, and #10) with orders for blood sugar monitoring resulting in the shared use of glucometers.

The findings are:

Observation on 1/10/18 at 11:32 am of a finger stick blood sugar (FSBS) check revealed:
-The third floor morning medication aide (MA) opened a black glucometer case, labeled with a resident's name, containing a Brand B glucometer not labeled with a resident's name, and obtained a FSBS check for the resident named on the glucometer pouch.
-The MA used disposable gloves, an alcohol swab, a new test strip, and a single use disposable lancing device to perform the FSBS.
-The MA disposed of the test strip, lancing device, and alcohol wipe in the biohazard waste container affixed to the medication cart.

Observation of the front hall third floor medication cart on 1/10/18 at 11:45 am revealed:

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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
D932	Continued From page 27 -There were 3 black glucometer cases located on the medication cart. -Two of the black glucometer cases were labeled with residents' names and contained a Brand A glucometer not labeled with a resident's name. -One of the black glucometer cases was labeled with a resident's name and contained a Brand B glucometer not labeled with a resident's name. -No other glucometers were observed on the medication cart. Review of the CDC (Center for Disease Control and Prevention) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Telephone interview on 1/11/18 at 4:12 pm with the manufacturer of the Brand A glucometer revealed the glucometer was recommended for use by a single person and should not be shared. No disinfection procedures were recommended. Review of the owner's manual for Brand B glucometer revealed the "[brand name] Blood Glucose Monitoring System is for one person use ONLY. DO NOT share your Meter or your Lancing Device with anyone, including family members. DO NOT use on more than one person. ALL parts of the [brand name] Blood Glucose Monitoring System could carry bloodborne pathogens after use, even after cleaning and disinfection". Interview on 1/11/18 at 9:00 am with a facility Licensed Practical Nurse (LPN) revealed 10	D932		

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	HAL060019	A. BUILDING: _____ B. WING _____	01/12/2018

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D932	Continued From page 28 residents were administered FSBS and no resident receiving FSBS had a diagnoses of a blood borne pathogen. Interview with a facility LPN on 1/11/18 at 2:20 pm revealed: -The facility policy was for each resident to have a glucometer assigned to the resident, and used only on the assigned resident. -The facility had disinfectant wipes on the medication carts for disinfecting the resident's glucometers. -The facility did not have a routine disinfecting schedule for glucometers. -The facility had a system in place to randomly audit the current FSBS value in a glucometer's history compared to the current FSBS value documented on the resident's electronic Medication Administration Record (eMAR), however the audit system did review the glucometer's history for more than the one reading audited. -The LPN was not aware if glucometers used by residents were approved for use on more than one resident. A. Review of Resident #10's current FL2 dated 11/29/17 revealed diagnoses included esophageal reflux, hyperlipidemia, and Type II or unspecified type diabetes mellitus insulin dependent diabetes-uncontrolled. Review of Resident #10's subsequent physician's orders dated 12/13/17 revealed an order for finger stick blood sugar checks 2 times a day. Review of Resident #10's record revealed an order dated 12/14/17 for Novolog insulin use per sliding scale twice a day. Sliding scale was as follows: 150-200= 2 units; 201-250= 4 units;	D932		

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D932	Continued From page 29 251-300= 6 units; 301-350= 8 units; Notify physician if greater than 350. Review of Resident #10's December 2017 and January 2018 electronic Medication Administration Record (eMAR) revealed: -A transcription entry for twice daily sliding scale insulin (SSI) administration Novolog insulin, use per sliding scale twice a day. Sliding scale was as follows: 150-200= 2 units; 201-250= 4 units; 251-300= 6 units; 301-350= 8 units; Notify physician if greater than 350 was transcribed on the eMARs beginning 12/14/17 to 1/14/18 and scheduled for administration at 7:00am and 4:00 pm daily. Review of Resident #10's Brand A glucometer revealed FSBS values recorded in the glucometer's history compared to values documented on Resident #10's December 2017 and January 2018 eMAR from 12/25/17 to 1/11/18 were inconsistent. Examples of inconsistencies are as follows: -Time and date were not set correctly. The time and date displayed on the glucometer was 1/11/18 at 12:57 pm on 1/11/18 at 10:58 am. -On 1/11/18 at 9:13 am, a FSBS reading of 251 matched the January 2018 eMAR on 1/11/18 at 7:17 am. -On 1/9/18 at 9:04 am, a FSBS reading of 183 matched the January 2018 eMAR on 1/9/18 at 7:09 am. -On 1/9/18 at 95:15 pm, a FSBS reading of 269 matched the January 2018 eMAR on 1/9/18 at 4:00 pm. -There was an additional FSBS reading recorded in the glucometer history on 1/9/18 at 9:21 pm of 190 that was not documented on the January 2018 eMAR on 1/9/18 (Corresponding to a FSBS	D932		

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D932	Continued From page 30 value documented on Resident # 9's January 2018 eMAR on 1/9/18 at 9:00 pm and not documented in Resident #9's glucometer's history). -A FSBS reading of 147 was documented on the January 2018 eMAR for 1/6/18 at 9:00 pm, but no FSBS reading recorded in the glucometer's history. -A FSBS reading of 165 was documented on the January 2018 eMAR for 1/5/18 at 7:00 am, but no FSBS reading recorded in the glucometer's history. -A FSBS reading of 208 was documented on the January 2018 eMAR for 1/3/18 at 7:00 am, but no FSBS reading recorded in the glucometer's history. -On 12/25/17 at 5:22 pm, a FSBS reading of 169 matched the December 2017 eMAR on 12/25/17 at 4:00 pm. -On 12/25/17 there was an additional FSBS reading recorded in the glucometer history at 1:24 pm of 393 that was not documented on the December 2017 eMAR on 12/25/17 (Corresponding to a FSBS value documented on Resident #8's December 2017 eMAR on 12/25/17 at 11:28 am and not documented in Resident #8's glucometer's history). Review of Resident #10's glucometer's history compared to the eMARS for December 2017 and January 2018 revealed: -Resident #10 had 9 FSBS values documented on the eMARs and not recorded in the glucometer's history. -There were 4 additional FSBS values recorded in Resident #10's glucometer's history that were not documented on the resident's eMAR; one FSBS value corresponded to a FSBS value documented for Resident #8, and one for Resident #9, that did not appear in the residents'	D932		

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D932	Continued From page 31 glucometer's history for those times. Interview on 1/12/18 at 10:08 am with Resident #10 revealed: -She was not aware of the type of glucometer used to check her FSBS. -Staff took her FSBS routinely 2 times a day. -'She sticks her hand out and lets the staff do their job". -She was not sure what her FSBS values usually were. Refer to interview on 1/11/18 at 2:15 pm with a first shift MA. Refer to interview on 1/11/18 at 4:00 pm with a second shift MA. Refer to interview on 1/12/18 at 11:10 am with the Resident Care Director (RCD). Refer to interview on 1/12/18 at 11:15 am with the Business Office Manager. Refer to interview on 1/12/18 at 11:52 am with the Executive Director. B. Review of Resident #9's current FL2 dated 5/9/17 revealed: -Diagnoses included cerebrovascular disease, difficulty in walking, and Type II diabetes mellitus without complications -A physician's order for Novolog insulin (a rapid acting insulin used to lower blood sugar levels) as sliding scale insulin (SSI) before meals and at bedtime. Sliding scale 201-250=2 unit, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-499=10 units, 500 plus notify MD(physician). -A physician's order for Levemir (a long acting insulin used to lower blood sugar) insulin	D932		

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D932	Continued From page 32 subcutaneously every morning. Review of Resident #9's record revealed a subsequent order dated 12/26/17 to continue SSI Novolog. Sliding scale 201-250=2 unit, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-499=10 units, 500-999 notify MD(physician), subcutaneously before meals and at bedtime. Review of Resident #9's December 2017 and January 2018 electronic Medication Administration Record (eMAR) revealed: -Novolog, sliding scale 201-250=2 unit, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-499=10 units, 500-999 notify MD(physician) was transcribed on the eMARs beginning 12/1/17 to 1/14/18 and scheduled for administration at 7:00 am, 11:00 am, 4:00 pm, and 9:00 pm daily. Review of Resident #9's Brand A glucometer revealed FSBS values recorded in the glucometer's history compared to values documented on Resident #9's December 2017 and January 2018 eMAR from 12/25/17 to 1/11/18 were inconsistent. Examples of inconsistencies are as follows: -Time and date were not set correctly. The time and date displayed on the glucometer was 1/10/18 at 10:29 am on 1/11/18 at 9:40 am. -On 1/9/18 at 10:55 am, a FSBS reading of 163 matched the January 2018 eMAR on 1/9/18 at 11:00 am. -On 1/9/18 at 9:00 pm, a FSBS reading of 190 was documented on the January 2018 eMAR with no corresponding FSBS value recorded in Resident #9's glucometer's history (Corresponded to a FSBS value recorded in	D932		

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D932	Continued From page 33 Resident #10's glucometer's history for the same date, but not documented on Resident #10's eMAR and no FSBS due for Resident #10 at that time). -A FSBS reading of 142 was documented on the January 2018 eMAR for 1/7/18 at 9:00 pm, but no FSBS reading recorded in the glucometer's history. -A FSBS reading of 123 was documented on the January 2018 eMAR for 1/6/18 at 9:00 pm, but no FSBS reading recorded in the glucometer's history. -A FSBS reading of 127 was documented on the January 2018 eMAR for 1/3/18 at 9:00 pm, but no FSBS reading recorded in the glucometer's history. -On 1/2/18 at 7:45 am, a FSBS reading of 139 matched the January 2018 eMAR on 1/3/18 at 7:00 am; with an additional FSBS reading recorded in the glucometer history on 1/2/18 at 8:17 am 208 that was not documented on the January 2018 eMAR on 1/3/18 (Corresponding to a FSBS value documented on Resident #10's January 2018 eMAR on 1/3/18 at 7:00 am and not documented in Resident #10's glucometer's history); and an additional FSBS reading recorded in the glucometer history on 1/2/18 at 8:34 am 265 that was not documented on the January 2018 eMAR on 1/3/18 (Corresponding to a FSBS value documented on Resident #8's January 2018 eMAR on 1/3/18 at 8:00 am and not documented in Resident #8's glucometer's history). Review of Resident #9's glucometer's history compared to the eMARS for December 2017 and January 2018 revealed: -Resident #9 had 5 FSBS values documented on the eMARs and not recorded in the glucometer's history; 1 FSBS value that was documented on	D932		

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D932	Continued From page 34 the eMARs with corresponding FSBS values recorded in the glucometer's history of another resident (Resident #10). -There were 4 additional FSBS values recorded in Resident #9's glucometer's history that were not documented on the resident's eMAR; one FSBS value corresponded to a FSBS value documented for Resident #8, two FSBS values that corresponded to FSBS values documented on the eMAR for Resident #10 that did not appear in the residents' glucometer's history for those times, and one extra FSBS value of 145 on 1/3/18 at 11:26 am that could not be determined where it was documented from the sampled residents.. Interview on 1/12/18 at 10:20 am with Resident #9 revealed: -She was not aware of the type of glucometer used to check her FSBS but thought the same type was used each time. -She did not know the value of her FSBS each time but she did ask if the FSBS value was alright on some occasions. -The MA staff gave her a shot of insulin if it was needed. Refer to interview on 1/11/18 at 2:15 pm with a first shift MA. Refer to interview on 1/11/18 at 4:00 pm with a second shift MA. Refer to interview on 1/12/18 at 11:10 am with the Resident Care Director (RCD). Refer to interview on 1/12/18 at 11:15 am with the Business Office Manager. Refer to interview on 1/12/18 at 11:52 am with the	D932		

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D932	Continued From page 35 Executive Director. C. Review of Resident #8's current FL2 dated 12/14/17 revealed diagnoses included hypertension, osteoporosis, and Type 2 diabetes mellitus. -A physician's order for Novolog insulin (a rapid acting insulin used to lower blood sugar levels) 6 units subcutaneously with breakfast, 11 units with lunch, and 5 units with dinner. Check blood sugar (FSBS) before meals and add 1 unit for 100-249, 2 units for 250-299, 3 units for 300-350, 4 units for greater than 350. -A physician's order for Lantus (a long acting insulin used to lower blood sugar) insulin subcutaneously 7 units every morning and 6 units at bedtime. Review of Resident #8's record revealed a subsequent order dated 1/4/18 to continue current orders for Lantus and Novolog. Review of Resident #8's December 2017 and January 2018 electronic Medication Administration Record (eMAR) from 12/25/17 to 1/10/18 revealed: -A transcription entry for Novolog insulin 6 units subcutaneously with breakfast, 11 units with lunch, and 5 units with dinner. Check blood sugar (FSBS) before meals and add 1 unit for 100-249, 2 units for 250-299, 3 units for 300-350, 4 units for greater than 350 was transcribed on the eMAR and scheduled for administration at 7:00 am, 11:00 am, and 5:00 pm daily. Review of Resident #8's Brand B glucometer revealed FSBS values recorded in the glucometer's history compared to values documented on Resident #8's December 2017 and January 2018 eMAR from 12/25/17 to	D932		

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D932	Continued From page 36 1/11/18 were inconsistent. Examples of inconsistencies were as follows: -Time and date were not set correctly. The time and date displayed on the glucometer was 11/18/17 at 8:56 am on 1/10/18 at 4:50 pm. -On 11/11/17 at 10:19 pm, a FSBS reading of 160 recorded in Resident #8's glucometer matched the January 2018 eMAR on 1/3/18 at 5:00 pm. -A FSBS reading of 145 was documented on the January 2018 eMAR for 1/3/18 at 11:00am, but no FSBS reading recorded in the glucometer's history. -A FSBS reading of 265 was documented on the January 2018 eMAR for 1/3/18 at 7:00 am, but no FSBS reading recorded in the glucometer's history. -On 12/25/17 at 11:00 am, a FSBS reading of 393 was documented on the January 2018 eMAR with no corresponding FSBS value recorded in Resident #8's glucometer's history (Corresponded to a FSBS value recorded in Resident #10's glucometer's history for the same date, but not documented on Resident #10's eMAR and no FSBS due for Resident #10 at that time). Review of Resident #8's glucometer's history compared to the eMARS from December 25, 2017 and January 11, 2018 revealed: -Resident #8 had 5 FSBS values documented on the eMARs and not recorded in the glucometer's history; 1 FSBS value that was documented on the eMARs with corresponding FSBS values recorded in the glucometer's history of another resident (Resident #10). -There was 1 additional FSBS value recorded in Resident #8's glucometer's history that was not documented on the resident's eMAR (11/09 at 12:13 am corresponding to 12/31/17 at 8:00 pm	D932		

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D932	Continued From page 37 FSBS value of 163). Interview on 1/12/18 at 10:13 am with Resident #8 revealed: -She brought her glucometer with her when admitted from another facility. -She was not aware of a time when her glucometer was not used to check her FSBS. -She depended on the facility staff to check her FSBS and administer insulin as ordered by her physician. Refer to interview on 1/11/18 at 2:15 pm with a first shift MA. Refer to interview on 1/11/18 at 4:00 pm with a second shift MA. Refer to interview on 1/12/18 at 11:10 am with the Resident Care Director (RCD). Refer to interview on 1/12/18 at 11:15 am with the Business Office Manager. Refer to interview on 1/12/18 at 11:52 am with the Executive Director. --- Interview on 1/11/18 at 2:15 pm with a first shift MA revealed: -The facility policy was each resident was assigned a glucometer for obtaining FSBS, and should not be shared between residents. -She routinely cleaned the glucometer with an alcohol swab after each use. -She did recall a time when she had used a glucometer other than the one assigned to a resident to check a resident's FSBS. -She was not aware of an audit to compare FSBS values documented on the residents' eMARS	D932		

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D932	Continued From page 38 compared to FSBS values recorded in the residents' glucometers' history. -She had received the state infection control training in 2017. -She had not observed another MA sharing glucometers. Interview on 1/11/18 at 4:00 pm with a second shift MA revealed: -The facility policy was never share a glucometer. -The facility nurse (LPN) checks the glucometers to the eMARS, but she does not know how often or the procedure used. -She wiped the glucometer with a disinfecting wipe anytime she used it. Interview on 1/12/18 at 11:10 am with the Resident Care Director (RCD) revealed: -The Business Office Manager (BOM) was in charge of tracking infection control training for the medication aides (MA). -She had been in her current position since October 2017. -She was responsible to train and orient MA staff, including training on infection prevention regarding not sharing glucometers between residents. -All residents receiving FSBS checks should have a glucometer assigned to the resident, and no sharing glucometers. -She was not aware MA staff were sharing glucometers. -She had not conducted an in-service training regarding infection prevention for glucometers until 1/11/18 (yesterday). Interview on 1/12/18 at 11:15 am with the Business Office Manager revealed: -She was responsible to track the training of MAs regarding the state approved annual infection	D932		

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D932	Continued From page 39 prevention training. -Once each month a nurse comes to the facility to offer the state class on infection prevention to newly hired staff and any staff needing the yearly update. -She was not responsible for auditing glucometers compared to residents' eMARs for consistency of glucometer's history with the FSBS values documented on the eMAR. Interview on 1/12/18 at 11:52 am with the Executive Director revealed: -The facility's nurses were responsible for auditing to assure the facility was compliant with infection prevention practices like the facility's policy for not sharing glucometers. -The RCD was responsible for orientation of medication aides and medication clinical skills validation, including the use of glucometers. -MA staff were trained during a basis orientation class at hire. -She was unable to locate a facility policy specific to infection prevention regarding glucometers. The facility's failure to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines placed residents receiving finger stick blood sugar checks with glucometers at risk due to possible exposure of blood borne pathogens by the sharing of glucometers. This was detrimental to the health, safety and welfare of the residents receiving FSBS checks with glucometers and constitutes a Type B violation. Review of the facility's Plan of Protection dated 1/11/18 revealed: -Current blood glucose meters are single use	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF CHARLOTTE	6000 PARK SOUTH DRIVE CHARLOTTE, NC 28210

(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
D932	Continued From page 40 only. The facility is purchasing new glucometers for each resident to ensure the integrity of our infection control. -New glucometers will be labeled and placed on the medication cart for use on next scheduled fingerstick (FSBS) check. -In-service training specific to glucometers and infection control provided to each medication aide manager and Nurse prior to utilizing equipment for next FSBS. (Prior to next scheduled shift). -The Resident Care Director (RCD) will provide quarterly in-service training specific to glucometers to all medication care managers and Nurses. -Individual glucometers for all new residents will be inspected and labeled upon admission. -A weekly audit to be conducted for 4 weeks reviewing the glucometer readings compared to the electronic Medication Administration Record for accuracy by the RCD. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2018.	D932		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (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 an adult care home or successfully completed all of the following:	D935		

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D935	Continued From page 41 (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: 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. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 medication aides sampled (Staff A) completed the 5, 10 or 15 hour medication training. The findings are:	D935		

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D935	Continued From page 42 Review of Staff A's personnel file revealed: -Staff A was hired on 3/23/17 as a personal care aide. -Staff A had a position change to medication aide (MA) on 8/30/17. -There was documentation that a medication clinical skills validation was completed on 8/28/17. -There was documentation that Staff A passed the written medication exam for adult care homes on 7/25/17. -There was documentation of 24 credit hours of MA training completed on 3/17/17 at a previous facility. -There was no documentation for the 5, 10 or 15 hour MA training. -Staff A was not listed on the medication aide registry for skilled nursing homes. Telephone interview on 1/12/18 at 1:04 pm with Staff A revealed: -Staff A had taken a 24 hour MA course designed for skilled nursing facilities. -She had taken the written medication exam for adult care homes since she worked in assisted living. -She did not realize that the MA training and test was different for assisted living and skilled nursing. -She did not have 5, 10 or 15 hour training as a MA for assisted living. -She thought the 24 hour training course took the place of the 15 hour MA training. -She planned on completing the required training as soon as possible. Review of the November 2017, December 2017 and January 2018 electronic Medication Administration Records revealed Staff A had documented administration of medications to the	D935		

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D935	Continued From page 43 residents in the facility. Interview on 1/12/18 at 1:30 pm with the Resident Care Director (RCD) revealed: -She was responsible for ensuring MAs had all required training. -The contracted pharmacy provided the 15 hour MA training on a regular schedule every few months. -The next available training would be the middle of February. -She was aware that Staff A did not have the 5, 10 or 15 hour MA training. -She thought the 24 hour MA training Staff A had counted as her 15 hour training. Interview on 1/12/18 at 1:49 pm with the Executive Director revealed: -The RCD was responsible for assuring that all medication aides had the required training. -She would schedule Staff A for the February class for the 15 hour medication training. -Staff A would work in housekeeping and dining until her training was complete.	D935		