STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023011	A. BUILDING: _____ B. WING _____	11/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SHELBY	1425 E MARION STREET SHELBY, NC 28150

(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 October 30 and 31, 2018 with a telephone exit date of November 5, 2018.	D 000	The following is a plan of Correction for Brookdale Shelby, Shelby NC regarding the Statement of Deficiencies dated November 5th, 2018. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies, or any related Sanction or fines. Rather, it is submitted as Confirmation of our ongoing efforts to Comply with statutory and regulatory Requirements. In this document, we have Outlined specific actions in response to Identified issues. We have not provided a Detailed response to each allegation or Finding, nor have we identified mitigating factors. We remain committed to the Delivery of quality of health care services and will continue to make changes and improvement to satisfy that objective.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the primary care provider (PCP) was notified regarding fingerstick blood sugar (FSBS) results which were outside the ordered parameters for 1 of 5 residents (Resident #1). The findings are: Review of Resident #1's current FL2 dated 04/18/18 revealed: -Diagnoses included diabetes mellitus. -There was an order to perform FSBS checks two times daily. If under 70, give orange juice and peanut butter and recheck in thirty minutes. Review of a subsequent physician's order dated 08/10/18 revealed an order to perform FSBS checks three times daily before breakfast, before supper and at bedtime. If under 70 give orange juice and peanut butter and recheck in thirty minutes. Notify MD if less than 70 or greater than	D 273	-Resident #1's M.D. was made aware of all Blood Sugars by phone and fax on day of discovery (10/30/18). Appointment made for follow up on 11/3/18). No new orders from M.D. given after notification of blood sugars. New order received regarding recording of follow up blood sugars after initial low blood sugar. -All Med Tech's were in serviced and informed the need to document contact to M.D. for Blood Sugars outside of parameters as recorded in the order.	10/30/18 11/1/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Edie H. McCurry TITLE Executive Director (X6) DATE 12/15/18

Reviewed and Acknowledged by Joseph Cline, RN 12/17/18 Joseph Cline

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D 273	Continued From page 1 350. Call Emergency Medical Services (EMS) if symptomatic. Review of a second subsequent physician's order dated 08/10/18 revealed an order to check FSBS before breakfast and before supper and bedtime. FSBS logs were to be faxed to PCP in a week. Review of Resident #1's September and October 2018 electronic Medication Administration Records (eMAR) revealed: -There was an entry to check FSBS three times daily scheduled for 7:00am from 09/01/18 through 09/11/18 and then changed to 8:00am from 09/12/18 through 10/31/18, and scheduled for 5:00pm and 8:00pm from 09/01/18 through 10/31/18. -The entry included orders to give orange juice and peanut butter if the blood sugar was under 70 and recheck in thirty minutes. Notify PCP if less than 70 or greater than 350. Call EMS if symptomatic. -Resident #1's FSBS was documented as less than 70 for a total of nine times on 09/01/18 at 8:00pm, 09/13/18 at 5:00pm, 09/15/18 at 8:00pm, 10/04/18 at 8:00pm, 10/13/18 at 5:00pm, 10/15/18 at 5:00pm, 10/17/18 at 8:00pm, 10/19/18 at 8:00pm, and 10/24/18 at 8:00pm. -FSBS values under 70 ranged from 50-69. Review of Resident #1's record revealed: -There was documentation on 09/14/18 at 8:45am "called and spoke with Endo regarding residents FSBS readings and insulin order. Waiting a return call at this time." -There was documentation on 09/10/18, Resident #1's PCP was faxed a list of her FSBS readings from 08/18/18 through 09/10/18. -There was documentation on 10/05/18, Resident #1's PCP was faxed a list of her FSBS readings	D 273	-HWD or designee will monitor progress notes for residents with orders for parameter notification weekly times 3 months, monthly times 3 months and then spot check ongoing. -All new Med Tech's will be trained on notification upon hire during classroom orientation before working on Med cart independently. Audit tool to be kept and monitored by HWD or designee -If HWD or designee not available to audit notification of M.D. and documentation, Executive Director or Designee will monitor and record on audit tool. -	11/5/18 Ongoing Ongoing

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D 273	Continued From page 2 from 08/31/18 through 10/05/18. Interview with Resident #1 on 10/31/18 at 4:00pm revealed: -The medication aides (MA) checked her blood sugar three times a day. -When her blood sugar was less than 70, the MA would give her orange juice and peanut butter. -She did not know if the facility notified her PCP immediately, but she had been told they faxed the results to him periodically. -If her blood sugar was low, she would sometimes feel "jerky," but at times her blood sugar would be less than 70 and she would have no symptoms. Interview with a MA on 10/30/18 at 4:52pm revealed: -She routinely checked Resident #1's FSBS. -If Resident #1's FSBS was less than 70 during the PCP's business office hours, she would call the PCP's office immediately and if it ocurred outside of business hours, she would notify the PCP via fax. -She would document the contact with the PCP's office in Resident #1's record. -She had documented on Resident #1's eMAR, a FSBS of 56 on 10/15/18 at 5:00pm. -She could not explain why there was no documentation in Resident #1's record that she had notified the PCP's office. Interview with a second MA on 10/31/18 at 12:31pm revealed: -Resident #1 had an order for FSBS three times daily. -If she checked Resident #1's FSBS, and it was less than 70, she would give her peanut butter and orange juice and recheck her FSBS in twenty to thirty minutes.	D 273		

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D 273	Continued From page 3	D 273		

-If Resident #1's blood sugar recheck remained less than 70, she would call EMS and notify her PCP, but she had never had to do so.
-If Resident #1's blood sugar recheck had improved to a level over 70, she would not notify the PCP.
-She could not recall Resident #1 ever having a blood sugar less than 70.

Telephone interview with a third MA on 10/31/18 at 6:00pm revealed:
-Resident #1 had an order for FSBS three times daily.
-If Resident #1's FSBS was less than 70, she would give her orange juice and peanut butter and "check back in on her in a few minutes."
-She had documented on Resident #1's October 2018 eMAR, a FSBS of 66 on 10/04/18 at 8:00pm and a FSBS of 69 on 10/24/18 at 8:00pm.
-She had only learned this week she was supposed to recheck Resident #1's FSBS in thirty minutes if it was less than 70 and notify her PCP.
-"I guess I didn't read the order."
-She was trained by the Resident Care Coordinator (RCC) and two other MAs when she first started working at the facility, but she did not recall them training her to notify Resident #1's PCP if her FSBS was less than 70.

Interview with the RCC on 10/30/18 at 4:02pm revealed:
-Resident #1 had an order for FSBS three times daily.
-On the days she worked as an MA, if Resident #1's FSBS was less than 70, she would notify the PCP.
-She and the other MAs were to document the contact with the PCP's office in the resident log in Resident #1's record.
-She was responsible for training the MAs.

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D 273	Continued From page 4 -"Sometimes I forget to train the MAs on certain things until something like this comes up." Telephone interview with the Certified Medical Assistant (CMA) for Resident #1's PCP on 10/31/18 at 1:07pm revealed: -The PCP had been notified via phone on 09/14/18 regarding Resident #1's FSBS being less than 70 and had decreased her dose of insulin. -The PCP had not been notified of any other times in September and October 2018 when Resident #1's FSBS was less than 70. -The PCP's office had received one fax from the facility during the months of September and October 2018 on 10/05/18 with a list containing several months of Resident #1's FSBS readings. -If Resident #1's FSBS "was not too low, like around 68 or 69 and she was asymptomatic," the PCP expected the facility to treat her and recheck her FSBS in 30 minutes. If her FSBS improved upon recheck, the facility could notify his office the next day or within the same week via phone or fax. -If Resident #1's FSBS "was severely low, like 50, or if it did not improve after treatment with peanut butter and orange juice or if she was symptomatic," the PCP expected the facility to treat her, call EMS and notify his office immediately. Interview with the Administrator on 10/31/18 at 3:25pm revealed: -She did not know staff were not notifying Resident #1's physician when her FSBS was less than 70. -She expected the staff to follow the physician's orders. -She had previously designated the auditing of eMARs and glucometers to the Health and	D 273		

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D 273	Continued From page 5 Wellness Director (HWD), but since the current HWD was a new employee she had not assigned this task to her. -The RCC had not completed audits of the eMARs and glucometers because she had been working as a MA.	D 273	-	
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physicians' orders for 2 of 5 sampled residents regarding fingerstick blood sugar (FSBS) checks for Resident #1 and placement of a medicine patch used to treat Alzheimer's disease for Resident #5. The findings are: 1. Review of Resident #1's current FL2 dated 04/18/18 revealed: -Diagnoses included diabetes mellitus. -There was an order to perform FSBS checks two times daily. If under 70, give orange juice and peanut butter and recheck in thirty minutes.	D 276	-Resident #1's physician was notified immediately regarding blood sugars and repeat blood sugars after first check was below 70. M.D. was provided with list of all blood sugars in question and actions taken. M.D. gave new orders regarding recording the follow up blood sugars. New order was "OK not to record follow up blood sugars if repeat blood sugar is greater than 70. If resident is symptomatic EMS will be called and M.D. will be notified. -Med Techs educated regarding physician notification and recording of information that is listed in a physician's order. All new Med Tech's will be trained regarding physician notification before administering medications unsupervised. -HWD or designee to perform audit of Blood Sugar via glucometer memory to ensure that any blood sugars under 70 were repeated and reported to M.D. as ordered. Audit will be performed three times a week for 3 months, twice a week for 3 months and then once a week ongoing.	10/30/18 11/1/18 Started on 11/5/2018

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D 276	Continued From page 6 Review of a subsequent physician's order dated 08/10/18 revealed an order to perform FSBS checks three times daily before breakfast, before supper and at bedtime. If under 70 give orange juice and peanut butter and recheck in thirty minutes. Notify Primary Care Provider (PCP) if less than 70 or greater than 350. Call Emergency Medical Services (EMS) if symptomatic. Review of a second subsequent physician's order dated 08/10/18 revealed an order to check FSBS before breakfast and before supper and bedtime. FSBS logs were to be faxed to the PCP in a week. Review of Resident #1's September and October 2018 electronic Medication Administration Records (eMAR) revealed: -There was an entry to check FSBS three times daily scheduled for 7:00am from 09/01/18 through 09/11/18 and then changed to 8:00am from 09/12/18 through 10/31/18, and scheduled for 5:00pm and 8:00pm from 09/01/18 through 10/31/18. -The entry included orders to give orange juice and peanut butter if the blood sugar was under 70 and recheck in thirty minutes. Notify PCP if less than 70 or greater than 350. Call EMS if symptomatic. -Resident #1's FSBS was documented as less than 70 for a total of nine times on 09/01/18 at 8:00pm, 09/13/18 at 5:00pm, 09/15/18 at 8:00pm, 10/04/18 at 8:00pm, 10/13/18 at 5:00pm, 10/15/18 at 5:00pm, 10/17/18 at 8:00pm, 10/19/18 at 8:00pm, and 10/24/18 at 8:00pm. -FSBS values under 70 ranged from 50-69. -There was no documentation Resident #1's FSBS was rechecked in thirty minutes.	D 276	-New FSBS orders for new or existing residents will be added to the audit when order received or when resident admitted. HWD or designee to monitor.	

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D 276	Continued From page 7 Review of Resident #1's record revealed there was no documentation her blood sugar had been rechecked in thirty minutes following a result that was under 70. Review of Resident #1's glucometer's history revealed: -The time was not set correctly until 10/14/18. -On 09/01/18, there were six FSBS readings recorded. None of the readings matched the FSBS of 64 documented on the eMAR at 8:00pm. The last FSBS reading in the glucometer's history for 09/01/18 was 100 at 5:38pm. The next FSBS reading was on 09/02/18 at 3:30am. -On 09/13/18 at 12:37pm, a FSBS reading of 54 matched the September 2018 eMAR on 09/13/18 at 5:00pm. The next FSBS reading was on 09/13/18 at 4:12pm. -On 09/15/18 at 3:38pm, a FSBS reading of 50 matched the September 2018 eMAR on 09/15/18 at 8:00pm. The next FSBS reading was on 09/16/18 at 3:29am. -On 10/04/18, at 3:36pm, a FSBS reading of 66 matched the October 2018 eMAR on 10/04/18 at 8:00pm. The next FSBS reading was on 10/04/18 at 4:30pm. -On 10/13/18, at 12:42pm, a FSBS reading of 65 matched the October 2018 eMAR on 10/13/18 at 5:00pm. The next FSBS reading was on 10/13/18 at 7:47pm. -On 10/15/18, at 4:53pm, a FSBS reading of 56 matched the October 2018 eMAR on 10/15/18 at 5:00pm. The next FSBS reading was on 10/15/18 at 8:23pm. -On 10/17/18, there were two FSBS readings recorded. None of the readings matched the FSBS of 67 documented on the eMAR at 8:00pm. The last FSBS reading in the glucometer's history for 10/17/18 was 240 at 5:05pm. The next FSBS reading was on 10/19/18 at 7:47am.	D 276		

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D 276	Continued From page 8 -On 10/19/18, at 8:41pm, a FSBS reading of 65 matched the October 2018 eMAR on 10/19/18 at 8:00pm. The next FSBS reading was on 10/20/18 at 7:49am. -On 10/24/18, at 8:00pm, a FSBS reading of 69 matched the October 2018 eMAR on 10/24/18 at 8:00pm. The next FSBS reading was on 10/25/18 at 7:46am. Interview with Resident #1 on 10/31/18 at 4:00pm revealed: -The medication aides (MA) checked her blood sugar three times a day. -When her blood sugar was less than 70, the MA would give her orange juice and peanut butter. -"Sometimes they remembered to come back in and recheck it and sometimes they didn't." -She felt her blood sugar had always improved after drinking the orange juice and eating the peanut butter because she would feel "less hungry" so she had never requested staff recheck her blood sugar. -She had never fainted or been sent to the hospital due to a low blood sugar. Interview with a MA on 10/30/18 at 4:52pm revealed: -If a resident had blood sugar parameters that required her to recheck a blood sugar, the recheck would be documented in the resident's record because there was no place to document it on the eMAR. -If Resident #1's blood sugar was less than 70, she would give her orange juice and peanut butter and recheck her blood sugar in ten to thirty minutes. -She would document the FSBS recheck reading and interventions in Resident #1's medical record. -She had documented on Resident #1's eMAR, a	D 276		

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D 276	Continued From page 9 FSBS of 56 on 10/15/18 at 5:00pm. -She could not explain why there was no documentation of a recheck in Resident #1's record and no FSBS recheck reading in Resident #1's glucometer for 10/15/18. Interview with a second MA on 10/31/18 at 12:31pm revealed: -Resident #1 had an order for FSBS three times daily. -If she checked Resident #1's blood sugar, and it was less than 70, she would give her peanut butter and orange juice and recheck her blood sugar in twenty to thirty minutes. -If Resident #1's blood sugar recheck remained less than 70, she would call EMS, but she had never had to do so. -She could not recall Resident #1 ever having a blood sugar less than 70. Telephone interview with a third MA on 10/31/18 at 6:00pm revealed: -Resident #1 had an order for FSBS three times daily. -If Resident #1's blood sugar was less than 70, she would give her orange juice and peanut butter and "check back in on her in a few minutes." She had never rechecked her blood sugar. -She had documented on Resident #1's eMAR, a FSBS of 66 on 10/04/18 at 8:00pm and a FSBS of 69 on 10/24/18 at 8:00pm. -She had only learned this week she was supposed to recheck Resident #1's blood sugar in thirty minutes if it was less than 70. -"I guess I didn't read the order." -She was trained by the Resident Care Coordinator (RCC) and two other MAs when she first started working at the facility, but she did not recall them training her to recheck Resident #1's	D 276		

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D 276	Continued From page 10 blood sugar if it was less than 70. Interview with the RCC on 10/30/18 at 4:02pm revealed: -She had been employed at this facility for twelve years. -Resident #1 had an order for FSBS three times daily and to recheck it in 30 minutes if less than 70. -On the days she worked as an MA, if Resident #1's blood sugar was less than 70, she would give her orange juice and peanut butter and recheck her blood sugar in five to ten minutes. -She and the other MAs were to document the value of the blood sugar recheck and any interventions done in the resident log in Resident #1's record. -She had documented on Resident #1's eMAR, a FSBS of 54 on 09/13/18 at 5:00pm and a blood sugar of 65 on 10/19/18 at 8:00pm. -She could not explain why there was no documentation of a recheck in Resident #1's record and no FSBS recheck reading in Resident #1's glucometer for 09/13/18 and 10/19/18. -She was responsible for training the MAs. -"Sometimes I forget to train the MAs on certain things until something like this comes up." -She was responsible for auditing the eMARs and glucometers to assure physician's orders were being followed. -She had not audited the eMARs in several months because she had been working primarily as a MA and did not have time to perform RCC duties. Telephone interview with the Certified Medical Assistant (CMA) for Resident #1's PCP on 10/31/18 at 1:07pm revealed: -The PCP expected the facility to recheck Resident #1's blood sugar in thirty minutes if it	D 276		

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D 276	Continued From page 11 was below 70. -He did not know the facility was not rechecking Resident #1's blood sugar. -The risk to this resident of hypoglycemic episodes was severe, and if her blood sugar remained below 70 could lead to changes in her mental status, passing out, seizures and the need to call EMS for transport to the hospital. Interview with the Administrator on 10/31/18 at 3:25pm revealed: -She did not know Resident #1's blood sugar was not being rechecked in thirty minutes when it was less than 70. -She expected the staff to follow the physician's orders. -She had previously designated the auditing of eMARs and glucometers to the Health and Wellness Director (HWD), but since the current HWD was a new employee she had not assigned this task to her. -The RCC had not completed audits of the eMARs and glucometers because she had been working as a MA. 2. Review of Resident #5's current FL2 dated 08/29/18 revealed: -Diagnoses included Alzheimer's disease, diabetes, vitamin B12 deficiency, vitamin D deficiency, and sleep apnea. -There was a physician's order for Exelon 9.5mg patch (used to treat Alzheimer's disease) apply 1 patch daily. Review of Resident #5's physician visit summary notes dated 09/25/18 revealed a signed physician's order for Exelon patch to be applied and rotated on resident's arms only.	D 276	-Resident #5's M.D was notified of placement of Exelon Patch documented that areas were Left and Right Shoulder not arms as per written order. M.D. with no new orders at this time. -Med Tech's re-educated regarding specified placement of resident #5's Exelon Patch. Current order states to rotate on bilateral arms only.	

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D 276	Continued From page 12 Review of Resident #5's September 2018 electronic Medication Administration Record (eMAR) revealed: -A computer generated entry for Exelon patch 9.5mg apply 1 patch transdermally daily scheduled to be administered at 8:00am and removed at 9:00pm. -Exelon was documented as administered daily from 09/05/18 to 09/26/18 and order was discontinued on 09/26/18. -A computer generated entry for Exelon patch 9.5mg apply 1 patch transdermally daily rotate on arms scheduled to be administered at 8:00am and removed at 9:00pm started on 09/27/18. -Exelon was documented as administered daily from 09/27/18 to 09/30/18. -Exelon was documented as administered to the left or right shoulder for 4 out of 4 opportunities -Exelon was not documented as administered to the resident's left or right arm from 09/27/18 to 09/30/18. Review of Resident #5's October 2018 eMAR revealed: -A computer generated entry for Exelon patch 9.5mg apply 1 patch transdermally daily rotate on arms scheduled to be administered at 8:00am and removed at 9:00pm. -Exelon was documented as administered daily from 10/01/18 to 10/30/18. -Exelon was documented as administered to the left or right shoulder/scapula for 29 out of 30 opportunities -Exelon was documented as administered on the right upper arm on 10/02/18. Observation of Resident #5's medication on hand on 10/31/18 at 3:57pm revealed 21 Exelon patches available to be administered with the directions to apply 1 patch rotated on arms only	D 276	-HWD or designee to audit placement of patches per MAR/Progress notes weekly times three months, biweekly times 3 months then monthly ongoing for compliance. -Any new resident or new order for Exelon Patch will be placed on Audit for follow up. HWD or designee to monitor. -All new Med Techs will be trained regarding placement of patches and recording of placement per order before they administer medications unsupervised. This will be monitored by HWD or designee.	

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D 276	Continued From page 13 daily dispensed on 10/15/18. Interview with the medication aide (MA) on 10/31/18 at 1:10pm and 3:57pm revealed: -She applied Resident #5's patch to different areas of his back and arms. -She rotated the application site daily. -Resident #5 had a rash on his back but she would "try to not apply the patch to the areas with the rash." -Resident #5's skin under the patch would be red when she removed the patch. Interview with the Resident Care Coordinator/MA on 10/31/18 at 3:38pm revealed: -She knew that Resident #5 was only supposed to have his patch applied to his arms only. -She thought it was okay to apply the patch to the shoulder and scapula on the back. -Resident #5 had a rash on his back that was irritated if the patches were placed on his back. -The patches were suppose to be put on the arms only to avoid the rash. -She or the Executive Director (ED) was responsible for auditing the eMARs monthly to ensure all orders were being followed. Interview with the ED on 10/31/18 at 3:38pm revealed: -She had discussed with Resident #5's family member to suggest to the resident's physician to write an order to apply the Exelon patch to the arms only. -Resident #5 had a chronic rash that covered his entire back and torso. -The patch made the rash on Resident #5's back have increased redness and blisters. -She had recommended to get an order forthe Exelon patches to be applied to the arms only. -She did not know that the patches were being	D 276		

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D 276	Continued From page 14 applied to Resident #5's back and scapula on the back. Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable. Telephone interview with Resident #5's neurologist on 10/31/18 at 1:45pm was unsuccessful.	D 276		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason forthe omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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D 367	Continued From page 15 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure accurate documentation on the electronic Medication Administration Record (eMAR) for 2 of 6 sampled residents (Resident #1 and Resident #6) regarding fingerstick blood sugars (FSBS). The findings are: Observation of the facility's two medication carts on 10/31/18 at 10:14am revealed: -On cart A, there was a plastic box with Resident #1's name and room number written on it that contained an unlabeled black glucometer case with an unlabeled Brand A glucometer. -On cart B, there was a plastic box with Resident #6's name and room number written on it that contained an unlabeled black glucometer case with an unlabeled Brand B glucometer. 1. Review of Resident #1's current FL2 dated 04/18/18 revealed: -Diagnoses included diabetes mellitus. -There was an order to perform fingerstick blood sugar (FSBS) checks two times daily. If under 70, give orange juice and peanut butter and recheck in thirty minutes. Review of a subsequent physician's order dated 08/10/18 revealed an order to perform FSBS checks three times daily before breakfast, before supper and at bedtime. If under 70 give orange juice and peanut butter and recheck in thirty minutes. Notify Primary Care Provider (PCP) if less than 70 or greater than 350. Call Emergency Medical Services (EMS) if symptomatic. Review of a second subsequent physician's order dated 08/10/18 revealed an order to check FSBS	D 367	-Resident #1 and Resident #6's M.D. was notified of findings with no new orders at the time of notification. -New Glucometers were ordered for both resident #1 and #6. Current Glucometers thrown away in sharps container. New glucometers labeled with resident's name when arrived. Printed name labels replaced on glucometer case and plastic box that stores glucometer. Executive Director completed this task. HWD or designee to monitor Glucometer, glucometer case and plastic storage bin for proper labeling weekly ongoing. -All Med Techs completed re training on diabetic infection control and proper FSBS/diabetic management. This education was completed by the Executive Director who is a Registered Nurse. -Resident #6's MD discontinued the order for FSBS as resident is currently managed well on oral agent and FSBS review shows little variation from normal ranges. Resident #6 will be followed by Hgb A1C. HWD or designee will audit FSBS three times a week for 3 months, twice weekly times 3 months , then weekly ongoing. This audit will compare recorded FSBS in EMAR vs. Glucometer for accuracy of recording and insurance of completion of FSBS as ordered.	

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D 367	Continued From page 16 before breakfast and before supper and bedtime. FSBS logs were to be faxed to the PCP in a week. Review of Resident #1's September 2018 eMAR revealed there was an entry to check FSBS three times daily scheduled for 7:00am from 09/01/18 through 09/11/18 and then changed to 8:00am from 09/12/18 through 09/30/18, and scheduled for 5:00pm and 8:00pm from 09/01/18 through 09/30/18. Review of Resident #1's Brand A glucometer's history revealed FSBS values recorded in the glucometer's history compared to values documented on Resident #1's September 2018 eMAR were inconsistent. Examples of inconsistencies were as follows: -The time was not set correctly. The current date and time did not display when the glucometer was powered on. -On 09/01/18, at 3:28am, a FSBS reading of 120 matched the eMAR on 09/01/18 at 7:00am. -On 09/30/18, at 4:11pm, a FSBS reading of 128 matched the eMAR on 09/30/18 at 8:00pm. -On 09/01/18, at 5:00pm, a FSBS of 321 was documented on the eMAR that did not match any readings in the glucometer's history for 09/01/18. -On 09/01/18, at 8:00pm, a FSBS of 64 was documented on the eMAR that did not match any readings in the glucometer's history for 09/01/18. -On 09/04/18, at 4:21pm, a FSBS reading of 263 was documented on the eMAR as 261 at 8:00pm. -On 09/07/18, at 12:47pm, a FSBS reading of 238 was documented on the eMAR as 231 at 5:00pm. -On 09/08/18, at 12:20pm, a FSBS reading of 135 was documented on the eMAR as 137 at 5:00pm. -On 09/10/18, at 3:30am, a FSBS reading of 207 was documented on the eMAR as 203 at 7:00am. -On 09/11/18, at 3:40am, a FSBS reading of 213	D 367	-All new Med Tech's will have Diabetic Management, Infection Control and specific EMAR recording education before administering medications unsupervised. All new Med-Techs will complete a check off list of FSBS and recording before administering medications unsupervised. HWD or RN to complete training, check off return demonstration and follow up.	

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D 367	Continued From page 17	D 367		

was documented on the eMAR as 223 at 7:00am.
-On 09/14/18, at 12:40pm, a FSBS reading of 217 was documented on the eMAR as 207 at 7:00am.
-On 09/16/18, at 4:10pm, a FSBS reading of 248 was documented on the eMAR as 278 at 8:00pm.
-On 09/22/18, at 3:52pm, a FSBS reading of 282 was documented on the eMAR as 281 at 8:00pm.
-On 09/24/18, at 3:33am, a FSBS reading of 217 was documented on the eMAR as 207 at 7:00am.

Review of Resident #1's October 2018 eMAR revealed there was an entry to check FSBS three times daily scheduled for 8:00am, 5:00pm and 8:00pm.

Review of Resident #1's Brand A glucometer's history revealed FSBS values recorded in the glucometer's history compared to values documented on Resident #1's October 2018 eMAR were inconsistent. Example of inconsistencies were as follows:
-The time was not set correctly until 10/14/18.
-On 10/01/18, at 3:42am, a FSBS reading of 153 matched the October 2018 eMAR on 10/01/18 at 8:00am.
-On 10/14/18, at 7:47am, a FSBS reading of 148 matched the October 2018 eMAR on 10/14/18 at 8:00am.
-On 10/01/18, at 4:01pm, a FSBS reading of 254 was documented on the eMAR as 234 at 8:00pm.
-On 10/04/18, at 3:36am, a FSBS reading of 151 was documented on the eMAR as 152 at 8:00am.
-On 10/09/18, at 3:58pm, a FSBS reading of 276 was documented on the eMAR as 243 at 8:00pm.
-On 10/12/18, at 12:37pm, a FSBS reading of 208 was documented on the eMAR as 203 at 5:00pm.
-On 10/17/18, at 7:45am, a FSBS reading of 189 was documented on the eMAR as 178 at 8:00am.
-On 10/25/18, at 8:19pm, a FSBS reading of 233 was documented on the eMAR as 238 at 8:00pm.

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D 367	Continued From page 18 -On 10/30/18, at 4:59pm, a FSBS reading of 218 was documented on the eMAR as 215 at 5:00pm. Interview with the Resident Care Coordinator (RCC) on 10/31/18 at 3:14pm revealed Resident #1's FSBS documented on the eMAR and not being consistent with the glucometer's history was likely the result of MAs relying on their own memory to document FSBS. Refer to telephone interview with a medication aide (MA) on 10/31/18 at 5:24pm. Refer to telephone interview with a second MA on 10/31/18 at 6:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/31/18 at 3:14pm. Refer to interview with the Administrator on 10/31/18 at 3:25pm. 2. Review of Resident #6's current FL2 dated 04/19/18 revealed: -Diagnoses included diabetes with peripheral neuropathy. -There was an order to perform fingerstick blood sugar (FSBS) checks twice weekly. Review of Resident #6's September 2018 electronic medication administration record (eMAR) revealed there was an electronic entry to check FSBS twice weekly on Tuesdays and Fridays at 7:00am. Review of Resident #6's Brand B glucometer's history revealed: -FSBS values recorded in the glucometer's history did not match the values documented on Resident #6's September 2018 eMAR.	D 367		

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D 367	Continued From page 19 -There were no FSBS readings in the glucometer for 09/04/18, 09/07/18, 09/11/18 or 09/25/18. However, on the eMAR, FSBS readings were recorded as 113 at 7:00am on 09/04/18, 119 at 7:00am on 09/07/18, 124 at 7:00am on 09/ 11/18 and 111 at 7:00am on 09/28/18. Review of Resident #6's October 2018 eMAR revealed there was an electronic entry to check FSBS twice weekly on Tuesdays and Fridays at 7:00am. Review of Resident #6's Brand B glucometer's history revealed: -FSBS values recorded in the glucometer's history did not match the values documented on Resident #6's October 2018 eMAR. -There were no FSBS readings in the glucometer for 10/02/18, 10/05/18, 10/09/18, 10/23/18, or 10/26/18. However, on the eMAR, FSBS readings were recorded as 114 at 7:00am on 10/02/18, 111 at 7:00am on 10/05/18, 115 at 7:00am on 10/09/18, 113 at 7:00am on 10/23/18 and 124 at 7:00am on 10/26/18. Interview with the Resident Care Coordinator (RCC) on 10/31/18 at 3:14pm revealed the only explanation she could think of for Resident #6's FSBS being documented on the eMAR, but not found in the glucometer's history, was the possibility that his glucometer was not working properly. Refer to telephone interview with a medication aide (MA) on 10/31/18 at 5:24pm. Refer to telephone interview with a MA on 10/31/18 at 6:00pm. Refer to interview with the Resident Care	D 367		

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D 367	Continued From page 20 Coordinator (RCC) on 10/31/18 at 3:14pm. Refer to interview with the Administrator on 10/31/18 at 3:25pm. --- Telephone interview with a MA on 10/31/18 at 5:24pm revealed: -Three residents required FSBS. -One of the residents performed his own FSBS checks and kept his glucometer in his room. -After checking a FSBS, she could usually go directly back to her medication cart and record the blood sugar on the eMAR. -If she was not able to get back to the medication cart right away, she would look back through the glucometer's history prior to recording the blood sugar on the eMAR. Telephone interview with a second MA on 10/31/18 at 6:00pm revealed: -Often times, after checking a FSBS, she would become distracted by other residents prior to reaching her medication cart and being able to document the FSBS on the eMAR. -She knew she should refer back to the glucometer's history to assure her documentation was accurate on the eMAR but it was difficult to take the time to do so. "It gets busy with one MA for forty-four residents." Interview with the Resident Care Coordinator (RCC) on 10/31/18 at 3:14pm revealed: -Three residents in the facility required FSBS checks. -The MAs would often check a FSBS and then get distracted with helping other residents before they could get back to their medication cart and record the FSBS on the eMAR. -She was responsible for training the MAs, and	D 367		

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D 367	Continued From page 21 she had trained them to keep a pencil and paper in their pocket to record the FSBS on and refer to once they were able to return to the medication cart and document on the eMAR. -She was responsible for auditing the eMARs and comparing them to the glucometer histories. -She had not audited the eMARs in several months because she had been working primarily as a MA and did not have time to perform RCC duties. Interview with the Administrator on 10/31/18 at 3:25pm revealed: -She did not know some of the FSBS documented on the eMARs did not match the readings in their glucometers' histories. -She expected the MAs to not rely on their own memory when documenting FSBS on the eMAR. -She had previously designated the auditing of eMARs and glucometers to the Health and Wellness Director (HWD), but since the current HWD was a new employee she had not assigned this task to her. -The RCC had not completed audits of the eMARs and glucometers because she had been working as a MA.	D 367		
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 22 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. The findings are: 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 2 of 2 diabetic residents sampled (#1 and #6) with orders for blood sugar monitoring resulting in the shared use of glucometers. [Refer toTag 932 G.S. 131D-4.4 (A) (b) Ach Infection Prevention Requirements (Type B Violation)].	D912	- Resident #1 and Resident #6's M.D. was notified of findings with no new orders at the time of notification. -New Glucometers were ordered for both resident #1 and #6. Current Glucometers thrown away in sharps container. New glucometers labeled with resident's name when arrived. Printed name labels replaced on glucometer case and plastic box that stores glucometer. Executive Director completed this task. HWD or designee to monitor Glucometer, glucometer case and plastic storage bin for proper labeling weekly ongoing.	
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple	D932	-Med Techs had immediate retraining regarding infection control and diabetic management. Med Tech's were required to complete a Blood Glucose Testing/Monitoring Check off with a Registered Nurse before they were able to perform any further FSBS on residents. This retraining and check off was performed by the HWD and Executive Director, both whom are R.N.'s. -Med Techs will be required to complete demonstration of FSBS/Glucometer use monthly times 3 months, then quarterly times three months. HWD or RN to monitor and complete check off.	

			-Health Department notified of possible cross contamination related to glucometers. -M.D. of both resident #1 and #6 contacted about possible cross contamination. New orders received to complete HIV and Hepatitis Panel screening for both Residents #1 and #6. Screens were negative for both Resident #1 and #6. M.D., Health Department and residents notified of negative results. M.D. for both resident #1 and #6 state no further follow up regarding these tests. -HWD or designee to monitor labeling of glucometer, glucometer bag, and plastic storage container weekly ongoing to ensure that proper labeling is in place. HWD or designee will audit FSBS three times a week for 3 months, twice weekly times 3 months , then weekly ongoing. This audit will compare recorded FSBS in EMAR vs. Glucometer for accuracy of recording and insurance of completion of FSBS as ordered.	

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D932	Continued From page 23 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	D932	-All new residents or current residents with new order for FSBS will be ordered a new glucometer which will be labeled with residents name. Glucometer bag and storage box to also be labeled with resident's name. HWD or designee to monitor weekly for compliance. -All new Med-Techs will complete Infection Control and Diabetic Management training upon hire, before administering medications unsupervised. Med Tech's will complete a Blood Glucose Testing/competency check list supervised by RN before giving medications unsupervised. HWD or RN will monitor for compliance. -	

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D932	Continued From page 24 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 2 of 2 diabetic residents sampled (#1 and #6) with orders for blood sugar monitoring resulting in the shared use of glucometers. The findings are: Observation of the facility's two medication carts on 10/31/18 at 10:14am revealed: -On cart A, there was a plastic box with Resident #1's name and room number written on it that contained an unlabeled black glucometer case with an unlabeled Brand A glucometer. -On cart B, there was a plastic box with Resident #6's name and room number written on it that contained an unlabeled black glucometer case with an unlabeled Brand B glucometer. 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. Review of the cleaning and disinfection instructions for the Brand A glucometer revealed the glucometer was intended to be used by a single person and should not be shared. Review of the cleaning and disinfection instructions for the Brand B glucometer revealed	D932		

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D932	Continued From page 25 if the glucometer was to be used on multiple patients, cleaning and disinfection with an Environmental Protection Agency (EPA) approved disinfecting solution should be done between patients. Disinfecting would remove most, but not all possible infectious agents from the meter. 1. Review of Resident #1's current FL2 dated 04/18/18 revealed: -Diagnoses included diabetes mellitus, hypertension, dyslipidemia, depression, anxiety, gastroesophageal reflux disease and hypothyroidism. -There was an order to perform fingerstick blood sugar (FSBS) checks two times daily. If under 70, give orange juice and peanut butter and recheck in thirty minutes. Review of Resident #1's September 2018 electronic medication administration record (eMAR) revealed there was an entry to check FSBS three times daily scheduled for 7:00am from 09/01/18 through 09/11/18 and then changed to 8:00am from 09/12/18 through 09/30/18, and scheduled for 5:00pm and 8:00pm from 09/01/18 through 09/30/18. Review of Resident #1's Brand A glucometer's history revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #1's September 2018 eMAR. Example of inconsistencies were as follows: -The time was not set correctly. The current date and time did not display when the glucometer was powered on. -On 09/01/18, at 3:28am, a FSBS reading of 120 matched the September 2018 eMAR on 09/01/18 at 7:00am. -On 09/30/18, at 4:11pm, a FSBS reading of 128	D932		

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D932	Continued From page 26 matched the September 2018 eMAR on 09/30/18 at 8:00pm. -On 09/01/18, there were three additional FSBS readings in the glucometer's history that were not documented on the eMAR on 09/01/18 including a FSBS reading of 130 at 4:23pm, a FSBS reading of 98 at 5:10pm and a FSBS reading of 100 at 5:38pm. Review of Resident #1's October 2018 eMAR revealed there was an entry to check FSBS three times daily scheduled for 8:00am, 5:00pm and 8:00pm. Review of Resident #1's Brand A glucometer's history revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #1's October 2018 eMAR. Example of inconsistencies were as follows: -The time was not set correctly until 10/14/18. -On 10/01/18, at 3:42am, a FSBS reading of 153 matched the October 2018 eMAR on 10/01/18 at 8:00am. -On 10/14/18, at 7:47am, a FSBS reading of 148 matched the October 2018 eMAR on 10/14/18 at 8:00am. -On 10/17/18, there were two instead of three FSBS readings. At 7:45am, a FSBS reading of 189 was documented as 178 on the eMAR on 10/17/18 at 8:00am. At 5:05pm, a FSBS reading of 240 matched the October 2018 eMAR on 10/17/18 at 5:00pm. There was a documented FSBS reading of 67 on 10/17/18 at 8:00pm that was not in the glucometer's history. -There were no FSBS values in the glucometer's history for 10/18/18. There were documented FSBS readings on the eMAR on 10/18/18 including a reading of 175 at 8:00am, 139 at 5:00pm and 99 at 8:00pm.	D932		

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D932	Continued From page 27 Interview with Resident #1 on 10/31/18 at 4:00pm revealed: -The staff checked her blood sugar three times a day. -She kept a personal written log of her blood sugar readings. -Her glucometer had to be replaced about three months ago. -As far as she knew, the staff always used the same glucometer to check her blood sugar. Interview with a medication aide (MA) on 10/31/18 at 12:31pm revealed: -Her initials were on Resident #1's October 2018 eMAR for the documentation of the FSBS reading of 175 at 8:00am on 10/18/18 and the FSBS reading of 139 at 5:00pm on 10/18/18. -She could not recall checking Resident #1's blood sugar on 10/18/18. -She did not know why the FSBS readings she documented on Resident #1's eMAR were not in Resident #1's glucometer history, but matching readings were in Resident #6's glucometer history. Refer to interview with a medication aide (MA) on 10/31/18 at 12:31pm. Refer to telephone interview with a second MA on 10/31/18 at 5:24pm. Refer to telephone interview with a third MA on 10/31/18 at 6:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/31/18 at 3:14pm. Refer to interview with the Administrator on 10/31/18 at 3:25pm.	D932		

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D932	Continued From page 28 2. Review of Resident #6's current FL2 dated 04/19/18 revealed: -Diagnoses included hypertension, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, gastroesophageal reflux disease, diabetes with peripheral neuropathy, hyponatremia, mixed hearing loss, and benign prostatic hyperplasia. -There was an order to perform fingerstick blood sugar (FSBS) checks twice weekly. Review of Resident #6's September 2018 electronic medication administration record (eMAR) revealed there was an entry to check FSBS twice weekly on Tuesdays and Friday at 7:00am. Review of Resident #6's Brand B glucometer's history revealed: -FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #6's September 2018 eMAR. -There were no FSBS readings in the glucometer for 09/04/18, 09/07/18, 09/11/18 or 09/25/18. However, on the eMAR, FSBS readings were recorded as 113 at 7:00am on 09/04/18, 119 at 7:00am on 09/07/18, 124 at 7:00am on 09/ 11/18 and 111 at 7:00am on 09/28/18. Review of Resident #6's Brand B glucometer's history revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #6's October 2018 eMAR. Example of inconsistencies were as follows: -There were no FSBS readings in the glucometer for 10/02/18, 10/05/18, 10/09/18, 10/23/18, or 10/26/18. However, on the eMAR, FSBS	D932		

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D932	Continued From page 29 readings were recorded as 114 at 7:00am on 10/02/18, 111 at 7:00am on 10/05/18, 115 at 7:00am on 10/09/18, 113 at 7:00am on 10/23/18 and 124 at 7:00am on 10/26/18. -There were three additional FSBS values in the glucometer's history not documented on Resident #6's October 2018 eMAR but documented on Resident #1's October eMAR including readings of 67 at 8:00pm on 10/17/18, 175 at 7:47am on 10/18/18 and 139 at 5:00pm on 10/18/18 . Interview with Resident #6 on 10/31/18 at 2:00pm revealed: -The staff checked his blood sugar one time each week. -He was not sure what day they typically checked his blood sugar. -He did not know if they always used the same glucometer to check his blood sugar. Refer to interview with a medication aide (MA) on 10/31/18 at 12:31pm. Refer to telephone interview with a second MA on 10/31/18 at 5:24pm. Refer to telephone interview with a third MA on 10/31/18 at 6:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/31/18 at 3:14pm. Refer to interview with the Administrator on 10/31/18 at 3:25pm. _____ Interview with a medication aide (MA) on 10/31/18 at 12:31pm revealed: -Three residents required FSBS checks. -One of the residents performed his own FSBS checks and kept his glucometer in his room.	D932		

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D932	Continued From page 30 -The other two residents' glucometers were kept in separate plastic boxes in separate medication carts with their name and room number written on the outside of the box. -She did not know if there were any other glucometers in the facility. -She had never used a resident's glucometer on a different resident. Telephone interview with a second MA on 10/31/18 at 5:24pm revealed: -Three residents required FSBS. -One of the residents performed his own FSBS checks and kept his glucometer in his room. -The other two residents' glucometers were kept in separate plastic boxes in separate medication carts with their name and room number written on the outside of the box. -She had never used a resident's glucometer on a different resident. "I wouldn't do that because they [the glucometers] are easy to tell apart. They look totally different." -The glucometers were cleaned after each use if there was visible blood. Telephone interview with a third MA on 10/31/18 at 6:00pm revealed: -Three residents required FSBS. -One of the residents performed his own FSBS checks and kept his glucometer in his room. -The other two residents' glucometers were kept in separate plastic boxes in separate medication carts with their name and room number written on the outside of the box. -She had never used a resident's glucometer on a different resident. -She cleaned the glucometers with an alcohol swab after each use. Interview with the Resident Care Coordinator	D932		

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D932	Continued From page 31 (RCC) on 10/31/18 at 3:14pm revealed: -She had been employed at this facility for twelve years. -Three residents in the facility required FSBS checks. -None of the three residents had a diagnosis of a blood borne disease. -One resident checked his own blood sugar and kept his glucometer in his room. -The other residents' glucometers were kept in separate plastic boxes in separate medication carts with their name written on the box. -The facility did not have any other glucometers. -She did not know Resident #6's glucometer had been used to check Resident #1's blood sugar on 10/17/18 and 10/18/18. -She had never used a resident's glucometer on a different resident. -She did not know why additional FSBS readings were found in Resident #1 and Resident #6's glucometer's history and not documented on their eMARS. -She was responsible for auditing the eMARs and comparing them to the glucometer histories. -She had not audited the eMARs in several months because she had been working primarily as a MA and did not have time to perform RCC duties. -She was responsible for training the MAs. -It was the facility's policy to not share glucometers between residents. Interview with the Administrator on 10/31/18 at 3:25pm revealed: -She did not know staff were sharing glucometers. -It was the facility's policy to not share glucometers between residents. -She was an RN and taught diabetic care training to the MAs which included training on infection	D932		

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D932	Continued From page 32 control and not sharing glucometers. -All MAs had completed the diabetic care training. -She observed all MAs and "signed them offon performing FSBS checks prior to them working on the medication cart." -She had "no explanation as to why the glucometers had been shared." -She had previously designated the auditing of eMARs and glucometers to the Health and Wellness Director (HWD), but since the current HWD was a new employee she had not assigned this task to her. -The RCC had not completed audits of the eMARs and glucometers because she had been working as a MA. 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 for Residents #1 and #6. This was detrimental to the health, safety and welfare of the residents receiving FSBS checks with glucometers and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/31/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 15, 2018.	D932		