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	HAL088015	A. BUILDING: _____ B. WING _____	R-C 09/19/2019

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KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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D 000	Initial Comments The Adult Care Licensure Section and the Transylvania County Department of Social Services conducted an annual, follow-up, and complaint investigation survey on September 17-19, 2019. The complaint investigation was initiated by the Transylvania County Department of Social Services on September 3, 2019.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report; the plan of correction is prepared solely as a matter of compliance with state law. All staff were retrained on Residents Rights in dealing with Dignity and Resident Rights to Privacy	11/01/19
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to assure all residents were treated with respect, consideration, dignity, and full recognition of individuality and right to privacy. The findings are: 1. Confidential interview with a former staff member on 09/03/2019 revealed during the week of August 18-24, 2019, she witnessed on two occasions two female residents in the shower room at the same time being undressed and showered with no privacy curtain pulled between them. Confidential interviews with personal care staff between 09/04/19 and 09/19/19 revealed: -Two staff stated that they have witnessed and participated in assisting with showering/dressing two female residents in the shower room with no privacy curtain pulled. -Both staff stated that they were trained that two	D 338	This training was completed by the Executive Director and Memory Care Manager on 09/20/19 during an all staff meeting. All staff reviewed and signed the Resident Rights Policy	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deanna Wilcox — TITLE: Executive Director — (X6) DATE: 10/25/19

Reviewed and acknowledged on 11/05/19 by Jennifer Enderlin RN

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D 338	Continued From page 1 residents of the same sex could be in the shower room together for showering. -One staff stated that she had witnessed this occuring 8-12 times over the past 3-4 months and was unaware that there was a shower curtain in the shower room that could be pulled to provide privacy. -One staff stated that one time, while in the shower room, a resident said "Is she showering with me?" and the other staff in the shower room replied to the resident "yes, it is faster". -One staff had helped give 2 showers in the shower room, in the past 3-4 months, without using the curtain to provide privacy. -One staff stated that management was not notified, because they were "trained that way, and did not think anything was wrong." Interview with the Resident Care Coordinator (RCC) on 09/11/19 at 1:00pm revealed: -It was not uncommon to have more than one resident in the shower room at a time. -One resident would be in the shower with the curtain pulled, while another resident would be near the sink getting their hair blow dried. -Residents were not dressed or undressed in front of other residents. Observation of the facility's common shower room on 09/17/19 at 12:55pm revealed: -There was a walk in shower area in the right corner of the room. -There was a shower curtain available for use in the walk in shower area. -There was a sink located near the toilet area, and a chair. Interview with the RCC on 09/19/19 at 9:20am revealed: -She expected staff to shower one resident at a	D 338	All staff were retrained on Resdient Rights in dealing with Respect and Consideration. This training was completed by the Executive Director and Memory Care Manager on 09/20/19 during an all staff meeting	11/1/19

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D 338	Continued From page 2 time. -When the curtain was closed to the walk in shower area, they would undress the resident getting in the shower, while they would blow dry another residents hair. Interview with the Administrator on 09/19/2019 at 5:15pm revealed: -She had never witnessed more than one resident in the shower room at a time. -She expected to only have one resident at a time in the shower room to protect their privacy. Refer to interview with the RCC on 09/19/19 at 9:30am. Refer to review of personnel records on 09/19/19. 2. Confidential interview with a former staff member on 09/03/2019 revealed during the week of August 18-24, 2019: -She witnessed a co-worker in the dining room, with other co-workers and residents around them, discuss how they walked in on two residents (a married couple sharing a room in the facility) having sex and what she had seen, stating that it was gross and similar to walking in on your parents. -She was told by a co-worker the size of a male resident's genitals. Confidential interviews with staff between 09/04/19 and 09/19/19 revealed: -Three staff witnessed a co-worker discuss the sex life of a married couple residing in the facility in the dining room, around other staff and residents. -One staff added that this co-worker is still employed at the facility and is on probation for this incident.	D 338	All staff were retrianed on Resident Rights in dealing with Respect and Consideration of privacy This training was completed by the Executive Director and Memory Care Manager on 09/20/19 during an all staff inservice.	11/01/19

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D 338	Continued From page 3 Interview with the Resident Care Coordinator (RCC) on 09/19/19 at 9:25am revealed: -She was not aware of any staff making inappropriate comments about other residents in front of other staff or residents. -Staff would be written up if she observed them do this, or if she was told of any incidents by other staff or residents. Interview with the Administrator on 09/19/2019 at 5:15pm revealed that: -She was informed by an staff member of another staff member's comments regarding residents in front of staff and other residents on or about August 23, 2019. -She pulled the two staff members into her office for further investigation and counseling. -She wrote-up the staff who discussed the residents sex life and who also made the comment of a male resident's genitals to her co-worker in front of the male resident. Refer to interview with the Resident Care Coordinator (RCC) on 09/19/19 at 9:30am. Refer to review of personnel records on 09/19/19. Interview with the RCC on 09/19/19 at 9:30am revealed: -The personal care aides (PCA's) were trained by the facility nurse and other PCA's on resident rights and personal care services. -She did not train the PCA's in the facility. Review of personnel records on 09/19/19 revealed all three staff had completed the 80 hour Personal Care Training and resident rights training, as required.	D 338		

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D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: The facility failed to assure diabetic residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to adult care home infection prevention requirements. 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 (CDC) guidelines to assure proper infection control procedures for the use of glucometers for 4 of 6 sampled diabetic residents (#5, #6, #8, and #9) with orders for blood sugar monitoring resulting in shared glucometers, and improperly disposing of single-use equipment used to puncture skin related to 1 medication aide (Staff C) disposing of 2 disposable lancet devices and one insulin flexpen needle into the garbage can on the medication cart. [Refer to Tag 932 G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (Type B Violation)].	D912	All staff were retrained on 09/20/19 in dealing with Resident Rights on the residents recieving appropriate care. This training was completed by the Executive Director and Memory Care Manager during an all staff meeting.	11/01/19

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D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules.	D932	Infection Prevention Requirements Policy was reviewed with all staff on 09/20/19 during an all staff meeting. This training was completed by the Executive Director and Memory Care Manager. The facility obtained new glucometers for all 6 residents on 09/19/19 by 4pm. The LHPS nurse retrained all Med Techs on Diabetic Care on 09/19/19.	11/01/19
	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.			

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D932	Continued From page 6 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 (CDC) guidelines to assure proper infection control procedures for the use of glucometers for 4 of 6 sampled diabetic residents (#5, #6, #8, and #9) with orders for blood sugar monitoring resulting in shared glucometers, and improperly disposing of single-use equipment used to puncture skin related to 1 medication aide (Staff C) disposing of 2 disposable lancet devices and one insulin flexpen needle into the garbage can on the medication cart. The findings are: 1. Review of the CDC guidelines for infection control revealed: -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	D932	An order was obtained on 10/24/19 from [redacted] to test all 6 residents for Hep. C. Tests were performed by Vista Labs. Nurse Practioner will be following these residents weekly for 6 weeks Any changes in condition between weekly visits will be reported to nurse practioner.	11/01/19

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D932	Continued From page 7 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 facility's Infection Control Policy did not contain information regarding procedure for checking fingerstick blood sugars (FSBS) or the use of glucometers. Observation of medication cart A on 09/17/19 at 11:30am revealed there were three glucometer cases labeled with resident's initials with glucometers inside the case. Observation of medication cart B on 09/17/19 at 11:30am revealed there were two glucometer cases labeled with resident's initials with glucometers inside the case. a. Review of Resident #5's current FL2 dated 07/08/19 revealed: -Diagnoses included diabetes mellitus type 2 and dementia with behavior disturbance. -Recommended level of care was documented as SCU. -There were no orders for FSBS testing. Review of Resident #5's physician orders dated 08/22/19 revealed: -There was a medication order for Novolog U-100 insulin (used to control high blood sugar) sliding scale. If blood sugar is 150-200, give 0 units. If 201-250, give 2 units. If 251-300, give 4 units. If 301-350, give 6 units. If 351-400, give 8 units. If	D932	The Transylvania County Health Dept. completed a retraining for the Executive Director and the Memory Care Manager on 10/08/19 on infection control, HepC signs and symptoms, prohibited sharing of glucometers and proper disposal of sharpes. All staff were retrained by the Executive Directors and the Memory Care Manager on 10/22/19 on infection control, HepC signs and symptoms, proper disposal of sharpes and the prohibited sharing of glucometers.	11/01/19

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D932	Continued From page 8 blood sugar is greater than 400, call MD. Inject per sliding scale before meals and at bedtime. -There was a medication order for Novolog U-100 insulin inject 8 units subcutaneously three times daily with meals. -There was a medication order for Lantus U-100 insulin (used to treat diabetes) inject 24 units subcutaneously at 7:30am daily. Observation of Resident #5's Brand A glucometer on 09/18/19 at 3:17pm revealed the glucometer case was labeled with Resident #5's initials on a piece of tape and the back of the glucometer was not labeled. Review of Resident #5's glucometer history compared to the eMARs for September 2019 revealed: -The date and time were correct when the glucometer was turned on reading 3:17pm on 09/18 with no year specified. -The glucometers history began on 09/10/19 at 4:32pm and ended on 09/18/19 at 11:36am. -There were 18 FSBS readings stored in the history on the glucometer. -There were 2 FSBS values missing from Resident #5's glucometer history on 09/13/19 at 7:37am and 11:32am that corresponded to FSBS values recorded in Resident #8's glucometer history. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Attempted telephone interview with the physician for Resident #5 on 09/19/19 at 4:16pm was unsuccessful due to the office was closed from 09/18/19 to 09/22/19.	D932	The Memory Care Manager implemented a weekly training on Infection Control Policies that started on 10/02/19 for all Med Techs for 6 weeks and monthly thereafter.	11/01/19

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D932	Continued From page 9 Refer to the interview with the Administrator on 09/19/19 at 1:15pm. b. Review of Resident #6's current FL2 dated 09/03/19 revealed: -Diagnoses included dementia, diabetes mellitus type 2, anxiety, and intellectual disabilities. -Recommended level of care was documented as SCU. -There was a physician order to check FSBS before meals and at bedtime. Observation of Resident #6's Brand A glucometer on 09/18/19 at 2:38pm revealed the glucometer case was labeled with Resident #6's initials on a piece of tape and the back of the glucometer was not labeled. Review of Resident #6's glucometer history compared to the eMARs for September 2019 revealed: -The date and time were correct when the glucometer was turned on reading 2:38pm on 09/18 with no year specified. -The glucometers history began on 09/10/19 at 11:21pm and ended on 09/18/19 at 11:44am. -There were 23 readings stored in the history on the glucometer. -There were 2 FSBS values missing from Resident #6's glucometer history on 09/13/19 at 7:34am and 11:45am that corresponded to FSBS values recorded in Resident #8's glucometer history. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with the physician for Resident #6 on 09/19/19 at 4:16pm was	D932	The Memory Care Manager implemented a glucometer log to monitor CGB readings and calibration for all residents with an order for FSBS on 09/20/19. Executive Director or designee will do random audits of glucometers and logs to compare readings to ensure compliance	11/01/19

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D932	Continued From page 10 unsuccessful. Refer to the interview with the Administrator on 09/19/19 at 1:15pm. c. Review of Resident #9's current FL2 dated 05/08/19 revealed: -Diagnoses included diabetes mellitus type 2, dementia with behavioral disturbances, and generalized anxiety disorder. -Recommended level of care was documented as SCU. Review of a physician order for Resident #9 dated 05/08/19 revealed an order to check blood sugar prior to meals and bedtime and inject subcutaneously per sliding scale at 7:30am, 11:30am, 5:00pm and 9:00pm. Observation of Resident #9's Brand A glucometer on 09/19/19 at 10:42am revealed the glucometer case was labeled with Resident #9's initials on a piece of tape and the back of the glucometer was labeled with the residents last name. Review of Resident #9's glucometer history compared to the eMARs for September 2019 revealed: -The date and time were not correct when the glucometer was turned on reading 2:58pm with the date as 04/01 with no year specified. -The glucometers history began on March 21st at 4:27pm and ended on April 1st at 11:11am. -There was one FSBS value missing from Resident #9's glucometer history on 09/17/19 at 11:53am that corresponded to FSBS values recorded in Resident #8's glucometer history. Review of Resident #9's September 2019 eMAR revealed:	D932		

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D932	Continued From page 11 -There was a computer generated entry to check a FSBS at 7:30am, 11:30am, 5:00pm, and 8:00pm. -There were two FSBS documented on 09/15/19 at 5:00pm and 8:00pm. -There were four FSBS documented daily from 09/16/19 to 09/18/19 at 7:30am, 11:30am, 5:00pm, and 8:00pm. -There was one FSBS documented on 09/19/19 at 7:30am. Based on observations, interviews, and record reviews it was determined Resident #9 was not interviewable. Attempted telephone interview with the physician for Resident #9 on 09/19/19 at 4:16pm was unsuccessful. Refer to the interview with the Administrator on 09/19/19 at 1:15pm. d. Review of Resident #8's current FL2 dated 05/02/19 revealed: -Diagnoses included diabetes mellitus type 2, alzheimer's dementia with psychotic features, and major depressive disorder. -Recommended level of care was documented as SCU. Review of a physician order for Resident #8 dated 05/02/19 revealed to check blood sugar prior to meals and inject subcutaneously per sliding scale at 7:30am, 11:30am, and 5:00pm. Observation of Resident #8's Brand A glucometer on 09/19/19 at 10:52am revealed the glucometer case was labeled with Resident #8's initials on a piece of tape and the back of the glucometer was not labeled.	D932		

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D932	Continued From page 12 Review of Resident #8's glucometer's history compared to the eMARS for September 2019 revealed: -The date and time were correct when the glucometer was turned on reading 10:52am on 09/19 with no year specified. -The glucometers history began on 09/03/19 at 11:47am and ended on 09/19/19 at 6:58am. -There were 51 readings stored in the history on the glucometer. -There was an additional FSBS reading recorded in the glucometer history on 09/13/19 at 7:37am of 126 that was not documented on the September eMAR on 09/13/19 (Corresponding to a FSBS value documented on Resident #5's September 2019 eMAR on 09/13/19 at 7:30am and not documented in Resident #5's glucometer history). -There was an additional FSBS reading recorded in the glucometer history on 09/13/19 at 11:32am of 133 that was not documented on the September eMAR on 09/13/19 (Corresponding to a FSBS value documented on Resident #5's September 2019 eMAR on 09/13/19 at 11:30am and not documented in Resident #5's glucometer history). -There was an additional FSBS reading recorded in the glucometer history on 09/13/19 at 7:34am of 237 that was not documented on the September eMAR on 09/13/19 (Corresponding to a FSBS value documented on Resident #6's September 2019 eMAR on 09/13/19 at 7:30am and not documented in Resident #6's glucometer history). -There was an additional FSBS reading recorded in the glucometer history on 09/13/19 at 11:45am of 328 that was not documented on the September eMAR on 09/13/19 (Corresponding to a FSBS value documented on Resident #6's	D932		

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	HAL088015	A. BUILDING: _____ B. WING _____	R-C 09/19/2019

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D932	Continued From page 13 September 2019 eMAR on 09/13/19 at 11:30am and not documented in Resident #6's glucometer history). -There was an additional FSBS reading recorded in the glucometer history on 09/17/19 at 11:53am of 111 that was not documented on the September eMAR on 09/17/19 (Corresponding to a FSBS value documented on Resident #9's September 2019 eMAR on 09/17/19 at 11:30am and not documented in Resident #9's glucometer history). Review of Resident #8's September 2019 eMAR revealed: -There was a computer generated entry to check FSBS four times a day at 7:30am, 11:30am, 5:00pm, and 8:00pm. -FSBS readings were documented three times daily from 09/03/19 to 09/18/19 at 7:30am, 11:30am, and 5:00pm. -FSBS readings were documented on 09/19/19 once at 7:30am. -There were 11 FSBS readings in the history on the glucometer that were not documented in the September 2019 eMAR. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable. Attempted telephone interview with the Nurse Practitioner for Resident #8 on 09/19/19 at 9:46am was unsuccessful. Refer to the interview with the Administrator on 09/19/19 at 1:15pm. 2. Observation of the noon medication pass on 09/18/19 from 11:36am to 11:50am revealed:	D932		

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D932	Continued From page 14 -At 11:36am, Staff C performed a finger stick blood sugar (FSBS) on one resident. -Staff C completed the FSBS, placed the disposable lancet device into her gloved hand, and then removed both gloves. -Staff C then placed the gloves with the used lancet device into the garbage can on the side of the medication cart. -At 11:43am, Staff C performed a FSBS on another resident. -Staff C completed the FSBS, placed the disposable lancet device into her gloved hand, and then removed both gloves. -Staff C then placed the gloves with the used lancet device into the garbage can on the side of the medication cart. -At 11:50am, Staff C administered insulin to the same resident with an insulin flex pen device. -Staff C removed the flex pen needle from the insulin flex pen, placed it in her gloved hand, and then removed both gloves. -Staff C then placed the gloves with the used flex pen needle into the garbage can on the side of the medication cart. Observation of the medication cart on 09/18/19 at 11:36am revealed there was a sharps (device or object used to puncture or lacerate the skin) container, approximately half full, attached to the side of the medication cart. Interview with Staff C on 09/18/19 at 2:40pm revealed: -She had been employed in the facility for one year. -She had been trained to place disposable lancet devices and flex pen needles into the sharps container after use. -"I don't know why I did that."	D932	All staff were retrained on 09/20/19 in dealing with proper disposal of sharpes and exposure and transmission of Blood Borne Pathogens This training was completed by the Executive Director and Memory Care Manager	11/01/19

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D932	Continued From page 15 Interview with the Resident Care Coordinator (RCC) on 09/18/19 at 3:30pm revealed: -She expected the MAs to dispose of sharps from FSBS and injections in the sharps container on the medication cart. -Sharps were not to be disposed of in the trash. -MA's were trained to dispose of all used lancet devices and needles in the sharps containers. Interview with the RCC on 09/19/19 at 2:45pm revealed the facility nurse was responsible for training MA's on diabetic care and infection control. Review of the CDC (Center for Disease Control and Prevention) guidelines for infection control revealed all needles and other sharps be placed in a sharps disposal container immediately after use. Review of the facility's Infection Control and Universal Precautions Policy revealed sharps including diabetic testing equipment or anything that is sharp and is contaminated or potentially contaminated must be discarded in a designated sharps container. Refer to the interview with the Administrator on 09/19/19 at 1:15pm. Interview with the Administrator on 09/19/19 at 1:15pm revealed she expected staff to follow policies and procedures related to infection control. The facility failed to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines for finger stick	D932		

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D932	Continued From page 16 blood sugar checks. The facility's failure placed the residents at risk to possible exposure and transmission of blood borne pathogens by sharing of glucometers for Residents (#5, #6, #8, and #9) and the improper disposal of lancet devices and needles during the medication pass. This failure was detrimental to the health, safety and welfare of the residents receiving FSBS checks and insulin injections and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/18/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 3, 2019.	D932		