STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079009	A. BUILDING: _____ B. WING _____	R 01/17/2020

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BROOKDALE EDEN	314 W KINGS HIGHWAYS EDEN, NC 27288

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D 000	Initial Comments The Adult Care Licensure Section and the Rockingham County Department of Social Services conducted an annual survey 01/15/20 through 01/17/20.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 1 of 3 sampled staff (Staff C) was tested for tuberculosis (TB) disease upon hire. The findings are: Review of Staff C's, medication aide (MA) personnel record revealed: -Staff C was hired on 11/11/19. -There was no documentation Staff C had a TB skin test upon hire. -There was a health record signed by Staff C and dated 11/14/19 indicating that Staff C would provide documentation of a TB skin test within the past 12 months. -There was documentation Staff C had a TB skin test placed on 01/07/20 and read as negative on	D 131		

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D 131	Continued From page 1 01/10/20. Interview with the Administrator on 01/17/20 at 10:00 am revealed: -Staff were tested for TB before employment. -Staff C's previous employer was supposed to provide a copy of Staff C's personnel record to the Administrator before Staff C started working at the facility. -Staff C's previous employer did not provide her with a copy of Staff C's personnel record. -Two weeks ago, Staff C's former employer told her Staff C's personnel record had been stolen from her office. -Staff C did not provide proof she had a TB skin test prior to employment at the facility. Telephone interviews with Staff C on 01/17/20 at 11:37 am, 11:52am and 3:10pm revealed: -She did not remember the date of her previous TB skin test. -She did not have proof of a TB skin test within one year before her hire date. -Her previous TB skin test was greater than one year ago according to a representative from the facility that administered her test. - The Administrator or the Health and Wellness Director (HWD) had called her former employer to request copies of her TB skin test documentation. Interview with the HWD on 01/17/20 at 3:20 pm revealed: -The Business Office Manager (BOM) was responsible for keeping track of TB skin tests. -Staff C's former employer said she would provide copies of Staff C's TB skin test, but she never did. Interview with the BOM on 01/17/20 at 3:27 pm	D 131		

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D 131	Continued From page 2 revealed: -TB skin tests were done before employees started working at the facility. -Staff C was supposed to bring her TB skin test information from her previous employer. -She told the HWD more than once that a TB skin test was needed for Staff C. -She did not know why Staff C was allowed to work before providing proof a of TB skin test. -She could not remember if she talked with the Administrator about this situation after Staff C reported to duty. Interview with the Administrator on 01/17/20 at 3:57 pm revealed: -She expected new staff to provide all required pre-employment paperwork. -The BOM was responsible for pre-employment paperwork. -Staff C had told her she had all her required paperwork, but the Administrator never saw it. -Staff C's former employer was supposed to provide Staff C's TB skin test record, but never did. -The BOM did not notify her that Staff C's TB skin test had not been done.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;	D 137		

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D 137	Continued From page 3 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired on 11/11/19. -There was no documentation a HCPR check was completed upon hire. Interview with the Administrator on 01/17/20 at 11:46 am revealed: -She could not locate Staff C's pre-employment HCPR check. -It may have been with other paperwork that had been discarded in the shredder. Interview with the HWD on 01/17/20 at 3:38 pm revealed the Administrator or the Business Office Manager (BOM) was responsible for completing the HCPR check. Interview with the BOM on 01/17/20 at 3:40 pm revealed: -The HCPR check was normally completed with all other pre-employment paperwork. -She did not have a copy of the HCPR check that was done in November 2019. Review of Staff C's HCPR verification revealed Staff C's HCPR check was completed on 01/16/20 with no substantiated findings.	D 137		

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D 344	10A NCAC 13F .1002(a) Medication Orders	D 344		

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 medication orders were clarified with the prescribing practitioner for 1 of 6 sampled residents (#8) related to fingerstick blood sugar (FSBS) and parameters for holding a long-acting insulin.

The findings are:

Review of Resident #8's current FL2 dated 04/23/19 revealed:
-Diagnoses included diabetes mellitus with diabetic neuropathy.
-There was an order to check fingerstick blood sugars (FSBS) daily. If less than 60, hold insulin

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and diabetic medications, give ½ glass of orange juice, milk or crackers. Notify MD (physician) if sugar does not increase. If greater than 300 notify MD.
-There was an order for Lantus insulin 100units/ml (a long acting insulin used to control blood sugar levels) 35 units subcutaneously each morning.

Review of Resident #8's subsequent physician's order dated 08/15/19 revealed there was an order for FSBS to be taken daily. If less than 60, hold insulin and diabetic medications, give ½ glass of orange juice, milk or crackers. Notify MD if sugar does not increase. If greater than 300 notify MD.

Review of Resident #8's subsequent physician's order dated 09/13/19 revealed:
-There was an order for Lantus insulin 20 units at bedtime.
-There was no order regarding FSBS for Resident #8.

Review of Resident #8's record revealed laboratory reports with hemoglobin A1C (HgbA1C) values documented as 7.4 on 12/18/19 and 7.0 on 09/18/19. (A HgbA1C reflects the average blood sugar level for the past 2 to 3 months; a result of 7.0 or less is a common treatment target for diabetics).

Review of Resident #8's November 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check FSBS daily. If less than 60, hold insulin and diabetic medications, and give ½ glass of orange juice,milk or crackers. Notify MD if sugar does not increase. If greater than 300 notify MD. The FSBS was scheduled for 7:00am.

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-There were FSBS checks documented at 7:00am daily from 11/01/19 to 11/30/19 with a FSBS range of 83 to 173.
-There was an entry for Lantus insulin 20 units subcutaneously at bedtime, scheduled for 8:00pm with documented daily administration from 11/01/19 to 11/30/19.
-There was an additional FSBS value documented at 8:00pm with each Lantus administration from 11/01/19 to 11/30/19. The FSBS range was 170 to 317.

Review of Resident #8's December 2019 eMAR revealed:
-There was an entry to check FSBS daily. If less than 60, hold insulin and diabetic medications, and give ½ glass of orange juice, milk or crackers. Notify MD if sugar does not increase. If greater than 300 notify MD. The FSBS was scheduled for 7:00am.
-There were FSBS checks documented at 7:00am daily from 12/01/19 to 12/31/19 with a FSBS range from 102 to 165.
-There was an entry for Lantus insulin 20 units subcutaneously at bedtime, scheduled for 8:00pm with documented daily administration from 11/01/19 to 11/30/19.
-There was an additional FSBS value documented at 8:00pm with each Lantus administration from 12/01/19 to 12/31/19. The FSBS range was 161 to 364 (one value over 300).

Review of Resident #8's January 2020 eMAR revealed:
-There was an entry to check FSBS daily. If less than 60, hold insulin and diabetic medications, and give ½ glass of orange juice, milk or crackers. Notify MD if sugar does not increase. If greater than 300 notify MD. The FSBS was

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scheduled for 7:00am.
-There were FSBS checks documented at 7:00am daily from 01/01/20 to 01/16/20 with a FSBS range from 122 to 229.
-There was an entry for Lantus insulin 20 units subcutaneously at bedtime, scheduled for 8:00pm with documented daily administration from 01/01/20 to 01/16/20.
-There was an additional FSBS value documented at 8:00pm with each Lantus administration from 01/01/20 to 01/16/20. The FSBS range was from 160 to 269.

Interview with a second shift medication aide (MA) on 01/16/20 at 4:30pm revealed:
-Resident #8 had an order for Lantus 20 units at bedtime.
-She checked Resident #8's FSBS in the evening because documentation on the eMAR for Resident #8's Lantus prompted for a FSBS value when entering administration of the dose of Lantus.
-She was not responsible to enter residents' medication orders into the facility's eMAR system.

Interview with the Resident Care Coordinator (RCC) on 01/16/20 at 12:20pm revealed:
-She was a medication aide and administered medication mainly on first shift but also on second shift if staff called out.
-She administered medications to Resident #8 including Lantus insulin.
-She knew Resident #8 had an order for FSBS checks scheduled in the morning (7:00am).
-She did not know until recently when she administered medications in the evening that Resident #8's Lantus scheduled for 8:00pm prompted for a FSBS value when documenting administration. She had not called the primary care provider (PCP) to clarification of the insulin

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order.
-The facility entered orders into an in-house medication administration system and was responsible for clarifying any orders that were duplicated or unclear.
-She entered orders for residents into the facility eMAR system but the Lantus order for Resident #8 was entered before she started working as RCC.
-The RCC and the Health and Wellness Director (HWD) were responsible to check all orders entered into the eMAR system immediately after the orders were entered and before the MAs administered medications, and contact the residents' provider if orders were not clear.
-She had not called the primary care physician (PCP) when she noticed that resident had an order for FSBS once daily scheduled for 7:00am with parameters to hold insulin if FSBS was less than 60 with Lantus ordered at night with an additional FSBS required to be documented.
-She expected the MAs to communicate with the nursing staff and the nursing staff to follow up with a physician about any questions they had with a medication order.

Interview with the Administrator on 01/17/20 at 3:50 pm revealed:
-The RCC and HWD were responsible for clarifying medication orders.
-Resident #8's order for FSBS once daily with parameters for holding insulin and diabetic medication for values less than 60 should have been clarified.
-She did not know why Resident #8's PCP was not contacted to get the FSBS moved to immedicately prior to the evening ALantus dose.

Interview with the HWD on 01/17/20 at 4:00pm revealed:

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D 344	Continued From page 9 -The HWD had been working as a medication aide a lot since 11/01/19 due to staffing shortage. -She was responsible for auditing residents' eMARs compared to physician's orders for accuracy of orders and clarification on any orders that were not clear. -She had not done an audit of Resident #8's medications in the last 4 months. -She did not realize Resident #8's FSBS was scheduled in the morning and Lantus scheduled in the evening. -She did not why Resident #8's order for FSBS once daily was not moved to at bedtime when the Lantus was scheduled to be administered. -She had not contacted Resident #8's PCP for clarification of the FSBS order being moved to at night with the Lantus which would allow Resident #8 to receive only one FSBS per day as ordered. Telephone interview with a representative for Resident #8's primary care physician (PCP) on 01/17/20 at 11:45am revealed: -There was no documentation Resident #8's PCP had been contacted to clarify when FSBS should be obtained either in the morning or just prior to administering Lantus. -The PCP did not want the resident to receive 2 FSBS daily since the resident's diabetes was stable. -The facility should have contacted the PCP to clarify the time for obtaining FSBS for Resident #8. -The FSBS should be before Lantus was administered. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable.	D 344		

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D912	Continued From page 10	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Adult Care Homes Infection Prevention Requirements. The findings are: Based on observation, record reviews, and interviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 7 sampled residents (Residents #5, #6, and #7) with diabetes, resulting in sharing glucometers between residents. [Refer to Tag 932 G.S. 131D-4.4A (b) Adult Care Homes Infection Prevention Requirements (Type B Violation)].	D912		

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D932	Continued From page 11	D932		
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. 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,	D932		

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D932	Continued From page 12 hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, record reviews, and interviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 7 sampled residents (Residents #5, #6, and #7) with diabetes, resulting in sharing glucometers between residents. The Findings are: Review of the CDC 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.	D932		

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D932	Continued From page 13 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 and did not give any cleaning/disinfection instructions. Review of the cleaning and disinfection instructions for the Brand B glucometer revealed the glucometer was intended to be used by a single person and should not be shared and did not give any cleaning/disinfection instructions. Observation of a finger stick blood sugar (FSBS) check for a resident on 01/16/20 at 8:05 am revealed: -The medication aide (MA) retrieved a glucometer (Brand A) from the medication cart that was labeled with Resident #5's name. -She carried the glucometer to Resident #5's room. -She put on a pair of gloves, opened the pouch and turned on the glucometer labeled with Resident #5's name. -Next, she cleaned Resident #5's left index finger with alcohol and proceeded to prick her finger with a disposable lancet. -She placed a drop of blood on a test strip placed in the glucometer. -Results of the FSBS check was 104. -The MA placed the glucometer back in the labeled pouch and returned it to the medication cart. Observation of medication cart A on 01/16/20 at 10:31 am revealed: -There were six glucometer cases labeled with residents' names with glucometers inside the cases. -There were 6 glucometers of Brand A.	D932		

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BROOKDALE EDEN	314 W KINGS HIGHWAYS EDEN, NC 27288

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D932	Continued From page 14 Observation of medication cart B on 01/16/20 at 12:00 pm revealed: -There were five glucometer cases labeled with residents' names with glucometers inside the cases. -There were 4 glucometers Brand A and 1 glucometer Brand B. There were 11 residents in the building with orders for FSBS checks and disposable lancets were available for use. 1. Review of Resident #5's current FL2 dated 02/11/19 revealed diagnoses included pneumonia. Review of Resident #5's physician order dated 08/06/19 revealed to check finger stick blood sugar (FSBS) two times a day. Review of Resident #5's January 2020 electronic medication administration record (eMAR) revealed there was an entry to check FSBS two times a day, scheduled at 8:00 am and 4:00 pm. Review of Resident #5's Brand A glucometer's history on 01/16/19 at 10:30 am revealed: -The date and time were set correctly. - FSBS values were inconsistent compared to values documented on Resident #5's January 2020 eMAR. -FSBS values documented on Resident #5's January 2020 eMAR were not recorded in Resident #5's glucometer history with examples of inconsistencies as follows: -There were 2 FSBS readings that were documented on the eMAR that were not recorded in Resident #5's glucometer history. -On 01/11/20, FSBS value of 143 at 8:00 am was	D932		

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documented on the eMAR, but not recorded in Resident #5's glucometer history.
-On 01/12/20, FSBS value of 138 at 8:00 am was documented on the eMAR, but not recorded in Resident #5's glucometer history.
-There were FSBS values recorded in Resident #5's glucometer that did not match FSBS values documented on Resident #5's January 2020 eMAR.
-There were FSBS values on the January 2020 eMAR that did not match FSBS values recorded or documented in Resident #5, Resident #6, or Resident #7's glucometers or eMARs.

Refer to interview with a medication aide (MA) on 01/18/20 at 10:10 am.

Refer to interview with the Resident Care Coordinator (RCC) on 01/17/20 at 9:38 am.

Refer to interviews with the RCD on 01/17/20 at 9:19 and at 9:36 am.

Refer to interviews with the Administrator on 01/17/20 at 9:20 am and at 10:22 am

2. Review of Resident #6's current FL2 dated 12/09/19 revealed:
-Diagnoses included diabetes mellitus Type II.
-There was an order to check fingerstick blood sugars (FSBS's) as needed for signs and symptoms of hypoglycemia.

Review of Resident #6's January 2020 electronic medication administration record (eMAR) revealed there was an entry to check FSBS as needed for signs and symptoms of hypoglycemia that was changed to scheduled two times a day beginning 12/12/19, scheduled for 6:00 am and 8:00 pm.

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D932	Continued From page 16 Review of Resident #6's Brand A glucometer's history on 01/16/20 revealed: - FSBS values were inconsistent compared to values documented on Resident #6's January 2020 eMAR. -FSBS values documented on Resident #6's January 2020 eMAR were not recorded in Resident #6's glucometer history with examples of inconsistencies as follows: -There were 2 FSBS values documented on the eMAR that were not recorded in Resident #6's glucometer history. -On 01/09/20, FSBS value of 165 at 8:00 pm was documented on the eMAR, but notrecorded in Resident #6's glucometer history. -On 01/15/20, FSBS value of 103 at 6:00 am was documented on the eMAR, but not recorded in Resident #6's glucometer history. -The FSBS value documented on the eMAR for 01/09/20 at 8:00 pm matched FSBS values recorded in the glucometer for Resident #5. -The FSBS value documented on the eMAR for 01/15/20 at 6:00 am matched FSBS values recorded in the glucometer for Resident #7. -There were FSBS values recorded in Resident #6's glucometer that did not match FSBS values documented on Resident #6's January 2020 eMAR. -There were FSBS values documented on the January 2020 eMAR that did not match FSBS values recorded or documented in Resident #6, Resident #5, or Resident #7's glucometers or eMARs.. Interview with Resident #6 on 01/17/20 at 10:30 am revealed: -Staff checked her FSBS every night. -She had not noticed a name on her glucometer. -She was not aware that someone else's	D932		

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D932	Continued From page 17 glucometer could have been used to check her FSBS. Refer to interview with a medication aide (MA) on 01/18/20 at 10:10 am. Refer to interview with the Resident Care Coordinator (RCC) on 01/17/20 at 9:38 am. Refer to interviews with the RCD on 01/17/20 at 9:19 and at 9:36 am. Refer to interviews with the Administrator on 01/17/20 at 9:20 am and at 10:22 am 3. Review of Resident #7's current FL2 dated 08/07/19 revealed: -Diagnoses included diabetes mellitus Type II. -There was an order to check fingerstick blood sugars (FSBS's) two times a day. Review of Resident #7's physician order dated 09/13/19 revealed to check finger stick blood sugar (FSBS) before meals and at bedtime. Review of Resident #7's January 2020 electronic medication administration record (eMAR) revealed there was an entry to check FSBS before meals and at bedtime, scheduled for 7:00 am, 11:00 am, 5:00 pm and 10:00 pm. Review of Resident #7's Brand A glucometer's history on 01/16/20 revealed: - FSBS values were inconsistent compared to values documented on Resident #7's January 2020 eMAR. -FSBS values documented on Resident #7's January 2020 eMAR were not recorded in Resident #7's glucometer history with examples of inconsistencies as follows:	D932		

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D932	Continued From page 18 -There were 5 FSBS values that were documented on the eMAR that were not recorded in Resident #7's glucometer history. -On 01/04/20, FSBS value of 215 at 7:00 am was documented on the eMAR, but not recorded in Resident #7's glucometer history. -On 01/05/20, FSBS value of 120 at 10:00 pm was documented on the eMAR, but not recorded in Resident #7's glucometer history. -On 01/06/20, FSBS value of 160 at 7:00 am was documented on the eMAR, but not recorded in Resident #7's glucometer history. -On 01/12/20, FSBS value of 284 at 7:00 am was documented on the eMAR, but not recorded in Resident #7's glucometer history. -On 01/15/20 FSBS value of 175 at 5:00 pm was documented on the eMAR, but not recorded in Resident #7's glucometer history. -There were FSBS values recorded in Resident #7's glucometer that did not match FSBS values documented on Resident #7's January 2020 eMAR. -There were FSBS values on the January 2020 eMAR that did not match FSBS recorded or documented in Resident #7, Resident #6, or Resident #5's glucometers or eMARs. Interview with Resident #7 on 01/18/20 at 9:05 am revealed: -Staff checked her FSBS 4 times per day. -She had not noticed her name was on her glucometer. -Sometimes her glucometer had problems and did not work properly. -Sometimes when her glucometer acted up, the MA used another resident's glucometer to check her FSBS. -There were no problems using another resident's glucometer because it was the same brand.	D932		

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D932	Continued From page 19 Telephone interview with Resident #7's Primary Care Provider (PCP) on 01/18/20 at 11:33 am revealed they did not know glucometers were being shared at the facility so he would check on her. Refer to interview with a medication aide (MA) on 01/18/20 at 10:10 am. Refer to interview with the Resident Care Coordinator (RCC) on 01/17/20 at 9:38 am. Refer to interviews with the Resident Care Director (RCD) on 01/17/20 at 9:19 and at 9:36 am. Refer to interviews with the Administrator on 01/17/20 at 9:20 am and at 10:22 am. _____ Interview with a MA on 01/18/20 at 10:10 am revealed: -She worked third shift and checked residents' FSBS before 7:00 am. -She was trained on glucometers in July 2019. -Each resident who received a FSBS had their name on their glucometer. -She had been told not to share glucometers between residents. Interview with the Resident Care Coordinator (RCC) on 01/17/20 at 9:38 am revealed: -She checked residents' FSBSs when she worked on the medication cart. -She checked the name on the glucometer prior to use. -The facility glucometer policy did not allow sharing of glucometers. -She had not been able to audit the glucometers recently due to having to work on the medication cart.	D932		

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D932	Continued From page 20 -She thought she last audited the glucometers in November 2019 for the month of October 2019. -Glucometer audits were supposed to be completed monthly. Interview with the Resident Care Director (RCD) on 01/17/20 at 9:19 am revealed: -She checked FSBSs when she worked on the medication cart. -Each resident had their own glucometer which was labeled, and the storage case was also labeled on the outside. -The MAs usually did the FSBSs for the residents. -The MAs were specifically told during their initial training that there were absolutely no sharing glucometers between residents. -She did not know glucometers were being shared between residents. Second interview with the RCD on 01/17/20 at 9:36 am revealed: -She was responsible for ensuring glucometers were not shared between residents. -Staff did not audit the glucometers specifically for sharing. -She expected the MAs to be knowledgeable and use glucometers correctly by not sharing. Interview with the Administrator on 01/17/20 at 9:20 am revealed: -She did not know glucometers were being shared between residents. -She had never observed staff sharing glucometers between residents. -The MAs were taught not to share glucometers between residents during their medication aide class and yearly during diabetic training. -The facility glucometer policy documented not to share glucometers between residents.	D932		

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D932	Continued From page 21 Second interview with the Administrator on 01/17/20 at 10:22 am revealed: -There were no residents who had orders for FSBS testing with a diagnosis of bloodborne illness. -She expected each resident to have their own glucometer. -She expected the MAs to report to her when glucometers were broken. -She did not know of any audits being done to ensure the glucometers were not shared. -She expected staff to never share glucometers. -The RCD was responsible for ensuring staff followed the glucometer policy. _____ The facility failed to implement infection control procedures consistent with CDC guidelines resulting in sharing of glucometers between residents placing residents at risk for possible exposure to bloodborne pathogen diseases for Residents #5, #6, and #7. This failure was detrimental to the health safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/16/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 2, 2020.	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.	D935		

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D935	Continued From page 22 (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: (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.	D935		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff C) who administered medications had completed the 5, 10, or 15-hour medication administration course prior to administering medication.

The findings are:

Review of Staff C's, medication aide (MA) personnel record revealed:
-Staff C was hired on 11/11/19.
-Staff C passed the written MA exam on 08/15/19.
-Staff C completed the medication clinical skills review on 11/25/19.
-Staff C completed the 15-hour medication administration training course on 01/09/20.

Review of a resident's November 2019 electronic Medication Administration Record (eMAR) revealed:
-Staff C documented administration of medication 1 day in November 2019 and 19 days in December 2019.
-Staff C documented administration of medication 8 days in January 2020 before completing the 15-hour medication administration course.

Interview with the Administrator on 01/17/20 at 10:00 am revealed:
-Staff C's previous employer was supposed to provide a copy Staff C's employee file to the Administrator before Staff C started working at

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the facility.
-Staff C's previous employer did not provide her with a copy of Staff C's employee file.
-Two weeks ago, Staff C's former employer told her Staff C's employee file had been stolen from her office.

Telephone interview with Staff C on 01/17/20 at 11:37 am revealed:
-She took the 15-hour course with the Health and Wellness Director (HWD) on 01/09/20.
-She had been administering medication independently before completing the 15-hour medication training course.

Interview with Staff C on 01/17/20 at 3:10 pm revealed:
-She had completed the 15-hour medication administration course in 2019.
-The Administrator and HWD knew she had completed the course in 2019.

Interview with the HWD on 01/17/20 at 3:20 pm revealed:
-She was responsible for training Staff C.
-Staff C told her she was a MA already and had previously completed the 15-hour course.
-Staff C's former employer was supposed to provide Staff C's records.
-Staff C's former employer did not provide Staff C's records.
-The facility's Registered Nurse informed her Staff C did not need the medication administration course because she was already a MA.
-Staff C began administering medication independently around 11/30/19.

Interview with the Administrator on 01/17/20 at 3:57 pm revealed:

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D935	Continued From page 25 -She expected new employees to provide all required pre-employment paperwork. -She thought Staff C did not need to complete the 5-hour medication administration course since she had completed the MA written exam before she was hired. -Staff C had previously completed the medication administration course, but the Administrator had not seen proof of completion. -Staff C's previous employer had never sent over a copy of Staff C's personnel file, so the medication administration course was completed at the facility.	D935		