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BROOKDALE LAWNDALE PARK	4400 LAWNDALE DRIVE GREENSBORO, NC 27455

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 12/15/15, 12/16/15 and 12/17/15.	D 000		
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: TYPE A2 VIOLATION Based on observation, record review, and interview, the facility failed to assure physician orders related to wound care of lower extremities were implemented resulting in amputations and physician notification regarding a resident's refusal of insulin and fingerstick blood sugar monitoring for 2 of 7 sampled residents (Resident #2 and #3). The findings are: A. Review of Resident #3's current FL2 dated 12/06/15 revealed diagnoses of right leg cellulitis, diabetes mellitus, amputation of right great and second toe and left great toe and second toe. Review of an Orthopedic physician office visit note dated 8/17/15 revealed a diagnosis of peripheral vascular disease. Observation of Resident #3 on 12/15/15 at 11:54 am revealed: -Resident #3 was in her room, limping while using	D 273		

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a rolling walker trying to get to the closet.
-The left foot was wrapped in thick gauze and covered with a self-adhesive dressing. The external dressing was clean and without exudate.

Review of Resident #3's record revealed:
-Resident #3 was discharged from the hospital on 8/24/15 after the right great toe was amputated with orders for home health to provide wound care.
-A physician order dated 9/01/15 instructed to continue with dressing changes daily to the left great toe and dry dressing changes daily to right great toe amputation site.
-A physician order dated 9/03/15 clarified previous order and instructed the facility staff to apply a dry sterile dressing to the surgical wound on the right foot and diabetic ulcer on the left great toe daily and home health was to provide wound care once a week for one week and twice a week for four weeks.
-The home health Nurse documented wound care was provided on 9/02, 9/04, 9/07, 9/09, 9/15, 9/17, 9/22, 9/24 and 9/30/15.
-A physician office visit form documented "Well healing ulcers on bilateral great toe, s/p [status post] amputation of great right toe."

Review of the September 2015 Medication Administration Record (MAR) revealed:
-An entry to apply a dry sterile dressing to right great toe [amputation site] and left great toe every day except Tuesday and Thursday.
-Tuesdays and Thursdays were marked out with an "X".
-There were no initials on 9/02/15 and 9/21/15 indicating dressing changes were not provided.
-The dressing changes were documented as completed on 9/04, 9/05, 9/06, 9/07, 9/09, 9/11, 9/12, 9/14, 9/18, 9/19 and 9/25/15 by facility

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Medication Aides (MA).
-The initials were circled on 9/13, 9/16, 9/20, 9/23, 9/26, 9/27, 9/28 and 9/30/15 indicating dressing changes were not provided.
-The was no documentation of explanation as to why the dressing changes were not provided on the back of the MARs.
-Resident #3 did not have documentation of wound care received to right great toe [amputation site] or left toe on 9/08, 9/10, 9/13, 9/16, 9/20, 9/21, 9/23, 9/26, 9/27, 9/28 and 9/29/15.

Review of Resident #3's record revealed:
-A physician order dated 9/30/15 with instructions for home health skilled nursing to perform wound care to right great toe amputation space 3 times a week for two weeks starting 10/01/15.
-There was no order to discontinue the daily wound care to the left great toe.
-The home health Nurse documented wound care to the right foot as provided on 10/01, 10/05, 10/08, 10/12, 10/14/15.
-There was no documentation the home health Nurse provided wound care to the left foot.
-A typed Orthopedic physician office visit note dated 10/13/15 which described new ulceration on the left great toe that was subsequently debrided and revealed a purulent abscess which was decompressed. There was no sign of systemic infection but this debridement "did probe almost down to the bone." The note also included orders to "continue dressing changes over the left great toe."
-An Orthopedic Physician office visit form dated 10/13/15 with instructions for "dressing changes daily."
-A physician discharge summary from the hospital dated 10/28/15, documented that Resident #3's left great toe and right second toe were

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amputated on 10/25/15.
-Resident #3 was admitted back to the facility with orders for home health to resume wound care on 11/02/15.

Review of the October 2015 MAR revealed:
-An entry to apply a dry sterile dressing to right great toe and left great toe every day except Tuesday and Thursday.
-From 10/01/15 through 10/27/15 staff initialed and circled their initials indicating dressing changes were not provided.
-There was no documentation of explanations as to why the dressing changes were not provided on the back of the MARs except on 10/01/15 staff documented, "Sterile dressing, not on cart, not provided".
-An entry to change dressing on left great toe that was documented as provided 10/15/15 through 10/23/15 by facility MAs.
-No wound care was documented on the left great toe by staff from 10/01/15 to 10/14/15.

Review of Resident #3's Record revealed:
-Resident #3 had an office visit with the Orthopedic surgeon on 11/12/15 with documentation the incisions were healing well. The physician ordered Resident #3's feet be washed daily and to apply band-aids as needed.
-On 11/13/15 and 11/16/15 the home health Nurse continued the previous order to provide wound care to the open areas on right foot with medihoney and a silver dressing and wrap both feet with dry gauze and self-adhesive dressing.
-Resident #3 had an office visit with the Orthopedic surgeon on 11/25/15 with documentation of osteomyelitis present in the left second toe. Plans were made to amputate the second left toe the following week.
-A physician discharge summary from the hospital

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D 273	Continued From page 4 dated 12/6/15, with documentation Resident #3's left second toe was amputated on 12/04/15. -Physician orders dated 12/08/15 with instructions for Home Health to evaluate co-morbid conditions including hypertension, diabetes mellitus, peripheral vascular disease. Dressing was to stay in place until Resident #3 was seen in Orthopedic surgeon's office on 12/17/15. Interview with Resident #3 on 12/16/15 at 10:36 am revealed: -The facility staff no longer put dressings on her feet because it only gets changed at the orthopedic surgeon's office. -The facility staff did apply dressings a long time ago, but could not remember when they stopped. -She had three separate surgeries and has had four toes amputated in the last few months. -She knew she was not to bear weight on the front of her feet. -She knew she was to elevate her feet as much as possible. Interview with Resident #3's Responsible Party (RP) on 12/16/15 at 10:55 am revealed: -Resident #3's physician told the RP that with her co-morbid conditions such as peripheral vascular disease and diabetes mellitus, the infection was likely to spread and it was very hard to prevent. -Resident #3 was "a picker" due to anxiety and often picked at scabs, fingers and toes which made healing even more of a challenge. -They called him whenever they thought she needed to be seen by a physician. -They just had a care meeting last week -Interview with the home health Nurse on 12/17/15 at 2:45 pm revealed: -She had only been working with Resident #3 for about two weeks.	D 273		

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-She did not know what the treatment orders were prior to her being assigned to Resident #3.
-She was unable to access data sets and orders prior to being assigned to Resident #3.
-She only has access to the current orders that were provided by the orthopedic surgeon since she started Resident #3's assignment.
-The home health Nurse that was previously assigned to Resident #3 was no longer employed by this home health agency.

Interview with a Medication Aide (MA) on 12/16/15 at 4:49 pm revealed:
-The procedure was, she would notify the nurse on-call and faxed the physician if she noted a change in skin condition with one of the residents.
-She never had an occasion to notify the facility Nurses or the physician about Resident #3.
-She never performed any wound care on Resident #3.
-She was aware that Resident #3 had wound care but she "never messed with it."

Interview with a second MA on 12/17/15 at 10:15 am revealed:
-She had performed wound care on Resident #3, but not recently and she did not know when she last did.
-She washed the resident's left toes with warm soap and water and applied non-stick gauze and secured with paper tape.
-She thinks this was ordered in October but was not sure.
-She was instructed how to perform wound care in her certified nurse aide class.
-She had not been offered training on clean dressing changes at this facility with her.
-She was never checked off with return demonstration at this facility on clean dressing changes and wound care.

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D 273	Continued From page 6 -The facility or home health nurses did not instruct her about Resident #3's wound care. Interview with a third MA on 12/17/15 at 10:27 am revealed: -She had performed wound care on Resident #3, but did not remember when this was. -She washed her left toes with warm soap and water and applied non-stick gauze and secured with roll gauze and medical tape. -She had worked at this facility for approximately a year and a half. -When she was first hired she did have a class that checked her off for clean dressing changes with return demonstration by the Health and Wellness Director (HWD). -The facility or home health nurses did not instruct her about Resident #3's wound care. Interview with the Resident Care Coordinator (RCC) on 12/17/15 at 10:47 am revealed: -She first learned of Resident #3's wound on 8/03/15 and she cleaned it and bandaged the wound. -She contacted the physician and the RP on 8/03/15 and reported to them that the toe as red and swollen. -The medication was started on 8/06/15, because it did not arrive at the facility until the morning of 8/06/15. -She verbally told the staff to clean and dress the wound and apply a band aid from 8/03/15 through 8/08/15. -Resident #3 would constantly pick at her toes and bandages and they had to replace the band aid more than just daily, because Resident #3 would take it off. -She did not know why there was not documentation by facility staff of the wound care from 8/03/15 through 8/08/15.	D 273		

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D 273	Continued From page 7 Interview with the Health and Wellness Director (HWD) on 12/17/15 at 11:23 am revealed: -The RCC informed her about Resident #3's wound initially, but did not remember exactly when she was informed. -She maintained daily communication with the home health Nurse and felt like the home health agency was providing wound care as ordered. -She did not know what the current wound care orders were for Resident #3 and could not give an account of the course of recent treatment. -Initials that were circled on the MAR indicated that the medication or treatment was not administered. -She was aware of Resident #3's tendency to pick at her toes and did not know why there were never orders to wrap the complete foot to prevent Resident #3 from accessing her toes. -She made sure Resident #3 attended follow-up physician office visits and notified the physician when there were adverse changes that required physician assessments. Interview with the Administrator on 12/17/15 at 2:15 pm revealed: -She was aware of Resident #3's tendency to pick at her toes and felt this behavior started the wounds and the adverse events that followed as reported by the RCC and HWD. -She was aware home health was providing wound care and expected facility staff to provide wound care on the days home health was not providing wound care. -She was aware Resident #3 was seen by the Orthopedic doctor on a regular basis and the facility made sure Resident #3 was seen for all of the follow-up visits ordered. -She expected the HWD would have communication with the home health Nurse and	D 273		

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there was no breeches in care provided.

Interview with Resident #3's Orthopedic surgeon's Nurse on 12/16/15 at 12:48 pm revealed:
-The Orthopedic surgeon was unavailable for interview.
-Resident #3's primary care physician referred Resident #3 to the surgeon and the first time this surgeon saw Resident #3 was in the hospital on 8/17/15.
-Resident #3 had the right great toe amputated on 8/21/15, the right second and left great toe amputated on 10/24/15 and on 12/04/15, the left second toe was amputated.
-She was not able to speak to the care provided to Resident #3 and only able to read the clinical notes.

Interview with Resident #3's primary care physician on 12/17/15 at 3:31 pm revealed:
-He expected his orders would be followed and initiated when received.

-He continued to be the PCP for Resident #3, but all wound care orders were obtained through the Orthopedic surgeon.
B. Review of Resident #2's current FL2 dated 10/22/15 revealed:
-Diagnoses included diabetes, hypertension, anemia, anxiety, and blindness.
-A physician's order for Lantus Solostar 20 units each morning and evening (Lantus is a long acting insulin used to lower elevated blood sugar levels), and Novolog Flexpen 5 units three times a day with meals (a short acting insulin used to lower elevated blood sugar levels).
-No order for finger stick blood sugar (FSBS) checks was noted.

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Review of Resident #2's record revealed:
-The resident log notes documented an admission date of 10/29/15.
-A physician's order dated 11/5/15 for fasting blood sugars daily and 2 hours after the largest meal.
-A physician's order dated 11/11/15 to check FSBS before meals and at bedtime.
-A physician's order dated 12/02/15 to continue to check FSBS before meals and at bedtime.
-There was no October 2015 Medication Administration Record (MAR) in the record.

Review of Resident #2's November 2015 MAR revealed:
-An entry for Lantus insulin 20 units twice daily scheduled for administration at 8 am and 8 pm from 11/01/15 to 11/30/15.
-There were circled initials with documentation recorded on the back of the MAR noting Resident #2 refused 7 of 60 scheduled Lantus doses 11/07, 11/09, 11/13, 11/16, 11/24, and 11/25/15 (2 doses).
-An entry for Novolog insulin 5 units three times daily scheduled for administration at 8:00 am, 12:00 pm and 4:00 pm from 11/01/15 to 11/30/15.
-There were circled initials with documentation recorded on the back of the MAR noting Resident #2 refused the Novolog 7 of 90 scheduled doses on 11/07, 11/09, 11/23, 11/26, 11/27 and 11/29/15.
-There were circled initials on 11/13/15 and 11/16/15 without documentation noting why Novolog was not administered.
-There were entries Novolog was not documented as administered on 11/13/15 and 11/23/15.
-An entry dated 11/05/15 for FSBS to be checked "two times a day, everyday and 2 hours after largest meal" and scheduled at 8:00 am and 8:00 pm from 11/06/15 to 11/13/15.

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D 273	Continued From page 10 -An entry for FSBS "before meals and at bedtime" and scheduled to be checked at 7:30 am, 11:30 am, 4:30 pm and 8:00 pm from 11/13/15 to 11/30/15. -There were documented entries on 11/06/15 and 11/10/15 that no "blood glucometer machine was available", so FSBS "was not checked" on these dates. -There were circled initials on 11/07/15 (2 times) and 11/09/15 without documentation noting why FSBS was not checked. -A Blood Glucose monitoring form for the period from 11/11/15 to 11/30/15 was attached to the November MAR. -Resident #2 refused her FSBS checks 7 of 48 scheduled checks on 11/22 at pre-lunch and pre-dinner, 11/23, 11/24, 11/25, 11/26, and 11/27/15. -Resident #2's blood sugar ranged between 60 to 421. Review of Resident #2's December 2015 MAR revealed: -An entry for Lantus insulin 20 units twice daily was scheduled for administration at 8:00 am and 8:00 pm. -There were circled initials with documentation recorded on the back of the MAR noting Resident #2 refused Lantus 10 of 30 scheduled doses on 12/03, 12/05 (2 doses), 12/06, 12/08 (2 doses), 12/10, 12/11, 12/13, and 12/15/15. -An entry for Novolog 5 units three times daily with meals was scheduled for administration at 8:00 am, 12:00 pm, and 5:00 pm. -There were circled initials with documentation recorded on the back of the MAR noting Resident #2 refused Novolog 13 of 45 scheduled administered doses on 12/03/15 (2 doses), 12/05 (2 doses), 12/06 (2 doses), 12/08 (2 doses), 12/10, 12/11, 12/12, 12/14, and 12/15/15.	D 273		

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D 273	Continued From page 11 -An entry for FSBS "before meals and at bedtime" was written on the MAR to be checked at 7:30 am, 11:30 am, 4:30 pm and 8:00 pm from 12/01/15 to 12/15/15. -A Blood Glucose monitoring form for the period from 12/01/15 to 12/16/15 was attached to the December MAR. -Resident #2 refused FSBS checks 26 of 60 scheduled checks on 12/01, 12/02, 12/03 (2 times), 12/04 (2 times), 12/05 (4 times), 12/06 (3 times), 12/07 (2 times), 12/08 (2 times), 12/09 (2 times), 12/10 (2 times), 12/11, 12/12, 12/14 (2 times), and 12/15/15. -Resident #2's blood sugar ranged from 70 to 417. Interview on 12/15/15 at 11:00 am with Resident #2 revealed: -She had been a resident at this facility for 5-6 weeks. -She was a diabetic on insulins and FSBS. -When she first moved in "they were checking my FSBS twice a day, but now they want to do it 5 times a day. My fingers are too sore, so I'm only letting them check it no more than 3 times a day. I do not know if they told my doctor. I have not seen my doctor recently, but I will tell her." -Her family "was well informed of my situation, because I tell them". Interview on 12/15/15 at 4:45 pm with a Medication Aide (MA) revealed: -If a resident refused FSBS checks "more than 3 to 5 days, she would fax the FSBS log to the physician for orders". -She was not aware if any staff had notified Resident #2's physician of her frequent refusals for FSBS checks.. -She had not notified the physician of Resident #2's refusal for FSBS checks.	D 273		

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D 273	Continued From page 12 Interview on 12/16/15 with Resident #2's primary care physician's Nurse Practitioner (NP) revealed: -She was not aware Resident #2 had been refusing her insulins and FSBS checks. -There were no notifications in her records the facility had notified her office of any medication or FSBS refusals. -"If her blood sugars were bottoming out that would be her biggest concern, but they were not." -She was concerned the facility had not notified her "especially about the insulin refusals". -Resident #2 was "alert and oriented", so "she could see how she (Resident #2) would refuse FSBS when her fingers were sore". -If Resident #2 continued to refuse her FSBS, she would prefer the resident allowed FSBS checks before breakfast and before dinner. -She would follow-up with the resident. Interview on 12/17/15 at 9:10 am with the Health and Wellness Director (HWD) revealed: -If there were issues with residents, like falls and refusals, the staff had several opportunities to report to management. The facility had a daily "stand-up meeting" for a 24 hour report to update staff and management of any issues. They could notify the HWD or the Resident Care Coordinator (RCC) of any concernes. -She was not aware Resident #2 was refusing her insulins and FSBS checks, and was not aware Resident #2's physician or NP was not notified. -The MA were to notify Resident #2's NP by fax and also Resident #2's family, "since they were so involved" that Resident #2 was refusing medications and FSBS. -Resident #2's NP visited the facility every week -The staff was to "notify the HWD each occurrence of refusal". -The staff were to fax Resident #2's NP "after 3	D 273		

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D 273	Continued From page 13 misses of a medication". Interview on 12/17/15 at 9:15 am with the RCC revealed: -She had worked at the facility for 10 months as the RCC. -Either a MA or the RCC verified or checked the MARs for accuracy before the next month's MAR was used. -The MA should fax the NP each time a resident refused a medication or a FSBS and seek follow-up orders. -There was no need to notify the RCC or HWD if a resident was refusing meds or orders. -She was not aware Resident #2 was refusing her insulins and FSBS checks, and was not aware Resident #2's physician or NP was not notified. Interview on 12/17/15 at 9:20 am with a second MA revealed: -She had worked at the facility for 3 years, and had been a MA for the past 2 years. -If a resident refused a medication or FSBS, she made a notation on the MAR that it was refused. If it was a continuous problem for more than 2 days, she faxed a note to the NP and awaited orders. She also reported it to the RCC and HWD at the daily "stand-up" meeting. Further review of Residen't #2's record revealed no documentation that her physician or NP was notified that she was frequently refusing her scheduled insulins and FSBS checks. Review of the facility's refusal policy for medication and treatment revealed: -The policy was last revised 6/2014. -The policy overview stated that "residents have the right to refuse medications and treatments provided by the community."	D 273		

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D 273	Continued From page 14 -"If a resident refuses a medication and/or treatment, the associate assisting with the medications should continue to offer the medication and/or treatment again within the acceptable timeframe." -"Documentation of the refusal should be made in the medication and/or treatment record." -"The nurse or designee should contact the physician/healthcare provider and legally responsible party to report the refusal. If the refusal could jeopardize the health of the resident, the physician should be contacted immediately." -"The nurse or designee should document that the resident and legally responsible party have been informed of the consequences of the refusal." -"Documentation in the resident record should include physician/healthcare provider notification along with physician/healthcare provider instructions and responsible party notification." _____ A plan of protection was provided by the facility on 12/17/15 as follows: -An immediate audit of resident records will be completed to identify any issues or concerns requiring referral or follow up needs. -All needs will be addressed immediately based on the above audit. -The Health and Wellness Director will review all physician order's and/or Home Health recommendation orders on a daily basis when in the community for 30 days, then weekly thereafter to ensure clarity of orders and appropiate follow-up. -Appropriate staff will be inserviced prior to next scheduled shift on proper reporting procedures for any questions regarding orders. DATE OF CORRECTION FOR THIS TYPE A2	D 273		

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D 273	Continued From page 15 VIOLATION SHALL NOT EXCEED January 16, 2016.	D 273		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure a quarterly assessment was completed for 2 of 2 sampled residents (Residents #5 and #6) in the Special Care Unit (SCU). The findings are: A. Review of Resident #5's current FL2 dated	D 464		

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6/11/15 revealed:
-Diagnoses included Alzheimer's disease and depression.
-Level of care was recommended as Memory Care (Special Care Unit [SCU]).
-Resident #5 was intermittently disoriented.
-Resident #5 required personal care assistance in bathing, feeding, dressing, and total care.

Review of the Resident Register for Resident #5 revealed an admission date of 6/15/15.

Review of Resident #5's record on 12/15/15 revealed:
-Care plans were dated 6/15/2015 and 7/15/15.
-No quarterly assessment and care plan had been completed since 7/15/15.

Refer to the interview on 12/16/15 at 9:50 am with the Health and Wellness Director (HWD) for the SCU.

Refer to the interview on 12/17/15 at 2:20 pm with the Executive Director.

B. Review of Resident #6's current FL2 dated 5/01/15 revealed:
-Diagnoses included Dementia, debility and history of falls.
-Level of care was recommended as SCU.
-Resident #6 was constantly disoriented.
-Resident #6 was wheelchair bound and needed assistance with bathing and dressing.

Review of Resident #6's Resident Register revealed an admission date to the SCU of 5/27/2008.

Review of Resident #6's record on 12/15/15 revealed:

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-Care plans for the year of 2015 were dated 3/23/15 and 9/23/15.
-A previous care plan from 2014 was dated 10/08/14.
-No quarterly assessment and care plans were completed, but were completed every 6 months.

Refer to the interview with the HWD for the SCU on 12/16/15 at 9:50 am.

Refer to the interview with the ED on 12/17/15 at 2:20 pm.

Interview with the HWD for the SCU on 12/16/15 at 9:50 am revealed:
-She had been at the facility as the HWD for the SCU for 11 months.
-She had worked at the facility as the Resident Care Coordinator in the Assisted Living area of the facility for one year before transferring to the SCU as their HWD.
-She thought resident assessments for the care plans in the SCU were to be done every 6 months until she "was informed by the County Adult Home Specialist less than one month ago that they were to be done quarterly".
-She had not started the quarterly assessments yet, but planned to do so going forward.
-She was responsible for having the quarterly assessments completed.

Interview with the ED on 12/17/15 at 2:20 pm revealed:
-The HWD was responsible for completing the resident care plans.
-Her expectations were that staff would complete the care plans as required.
-"The facility used a computer tracker for care plan assessment notifications. It was currently set for every 6 months, but would be reset for every 3

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D 464	Continued From page 18 months" to be in compliance with quarterly assessments in the SCU.	D 464		
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 observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care referral and follow-up and the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control regarding the sharing of glucometers and proper disinfection of fingerstick blood sugar (FSBS) monitoring equipment. The findings are: A. Based on observation, record review, and interview, the facility failed to ensure physician orders related to wound care of lower extremities were implemented resulting in amputations and failed to ensure follow up with a physician regarding a resident's refusal of insulin and fingerstick blood sugar monitoring for 2 out of 7 sampled residents (Resident #2 and #3). [Refer to Tag 273, 10A NCAC 10 F .0902(b) Health Care	D912		

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D912	Continued From page 19 (Type A2 Violation).] B. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control regarding the sharing of glucometers and proper disinfection of fingerstick blood sugar (FSBS) monitoring equipment. [Refer to Tag 932, G.S.131D-4.4 (b) ACH Infection Prevention Requirements (Type B Violation).]	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection 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	D932		

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D932	Continued From page 20 significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures consistent with Centers for Disease Control and Prevention guidelines on infection control regarding the sharing of glucometers and proper disinfection of fingerstick blood sugar (FSBS) monitoring equipment for 2 of 3 sampled residents (Residents #7 and #8). The findings are: Observation on 12/15/15 at 11:00 am of the medication carts and glucometer storage revealed: -There were four medication carts with a total of 13 glucometers, each stored inside a canvas pouch. -All the canvas pouches were labeled with a resident's name. -Eight of 13 glucometers were labeled with a	D932		

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D932	Continued From page 21	D932		

resident's name.
-Two of the 8 labeled glucometers (both Brand A) were labeled with a resident's name which did not match the name on the canvas pouch in which it was stored.
-Resident #7's glucometer was stored in a canvas pouch labeled with Resident #8's name.
-Resident #8's glucometer was stored in a canvas pouch labeled with Resident #7's name.
-Each of the medication carts included a container of EPA-approved disinfectant wipes.

A. Review of Resident #7's current FL-2 dated 11/11/15 revealed:
-Diagnoses included diabetes mellitus.
-A physician's order for FSBSs twice daily with insulin administration at breakfast and lunch if the FSBS was above 70.

Review of Resident #7's physician's orders revealed:
-An order dated 11/30/15 for FSBSs three times daily.
-An order dated 12/15/15 to discontinue FSBSs and insulin.

Review of Resident #7's October 2015 and November 2015 FSBS records revealed the FSBS was completed twice daily at 8:00 am and 12:00 pm.

Review of the December 2015 Medication Administration Record (MAR) revealed:
-The FSBS was scheduled daily at 8:00 am, 4:00 pm, and 8:00 pm.
-The FSBS was documented as completed on 12/01/15 at 8:00 am and 4:00 pm, then refused three times daily thereafter.

Review of the memory for the glucometer labeled

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D932	Continued From page 22	D932		

with Resident #7's name revealed:
-The date and time was not accurately set.
-The date and time of the stored FSBS results was unable to be determined.
-The last 24 FSBS results stored in Resident #7's glucometer memory corresponded with documentation of Resident #8's documented FSBS results from 12/01/15 through 12/15/15.
-FSBS stored results prior to the last 24 results did not match documentation for either Resident #7 or Resident #8.

Review of the Brand A glucometer instruction manual revealed:
-The glucometer was "intended to be used by a single person and should not be shared".
-The glucometer "should never be used by more than one person".
-The instruction manual did not include disinfecting instructions.

Interview on 12/16/15 at 12:00 pm with Resident #7 revealed:
-She had refused to allow staff to complete FSBS testing for "more than a month" because she did not like to see her fingers bleed.
-She did not know whether or not staff used her assigned glucometer to obtain the FSBSs.

Refer to interview on 12/15/15 at 11:05 am with a Medication Aide.

Refer to interview on 12/16/15 at 12:30 am with a second Medication Aide.

Refer to interview on 12/15/15 at 12:14 pm with the Resident Care Coordinator (RCC).

Refer to interview on 12/15/15 at 1:01 pm with the Health and Wellness Director.

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D932	Continued From page 23 B. Review of Resident #8's current FL-2 dated 06/07/15 revealed diagnoses included diabetes mellitus. Review of Resident #8's physician orders revealed an order dated 07/08/15 for fingerstick blood sugars (FSBS) twice daily. Review of the November 2015 Medication Administration Record (MAR) revealed the FSBS was documented as completed twice daily at 7:30 am and 4:30 pm. Review of the December 2015 MAR revealed the FSBS was documented as completed twice daily at 7:30 am and 4:30 pm. Review of the memory for the glucometer labeled with Resident #8's name revealed: -The date and time was accurately set. -There were no FSBS results in the glucometer memory since 12/02/15. -None of the FSBS results reviewed from 11/13/15 through 12/02/15 matched Resident #8's documented FSBSs. -FSBS results in Resident #8's glucometer from 11/13/15 through 11/30/15 matched documented FSBS results for Resident #7. Review of the Brand A glucometer instruction manual revealed: -The glucometer was "intended to be used by a single person and should not be shared". -The glucometer "should never be used by more than one person". -The instruction manual did not include disinfecting procedures. Interview on 12/16/15 at 12:15 pm with Resident	D932		

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D932	Continued From page 24 #8 revealed: -Staff routinely checked her FSBS twice daily before breakfast and before supper. -Her name was on her glucometer. -She never looked to see whether or not staff were using her assigned glucometer, but she trusted the staff to use the right one. Refer to interview on 12/15/15 at 11:05 am with a Medication Aide. Refer to interview on 12/16/15 at 12:30 am with a second Medication Aide. Refer to interview on 12/15/15 at 12:14 pm with the Resident Care Coordinator (RCC). Refer to interview on 12/15/15 at 1:01 pm with the Health and Wellness Director. _____ Interview on 12/15/15 at 11:05 am with a Medication Aide (MA) revealed: -She was not aware Residents #7 and #8's glucometers had been interchanged. -She did not know how long the glucometers had been in the wrong pouches. -The glucometers "should be" cleaned with alcohol wipes after each use. -No other cleaning or disinfecting agents were used on the glucometers. -Residents #7 and #8 were roommates and that was probably how the glucometers became interchanged. Interview on 12/16/15 at 12:30 am with a second MA revealed: -She was not aware Residents #7 and #8's glucometers had been interchanged. -She "usually" looked at the names on both the canvas pouch and the glucometer itself to ensure	D932		

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D932	Continued From page 25 she used the correct glucometer, but "probably" focused more on the name on the canvas pouch. -She routinely cleaned glucometers after each use with a disinfecting wipe for 5-7 seconds, then let the glucometer air dry. -When she arrived at work today, all the residents had new glucometers and both the canvas pouch and the glucometers were labeled with residents' names. Interview on 12/15/15 at 12:14 pm with the Resident Care Coordinator (RCC) revealed: -Every resident with orders for FSBSs had their own assigned glucometer. -The glucometers were not to be shared between residents. -The MAs were supposed to "wipe down" the glucometers with a disinfectant wipe after each use. -She was not aware some glucometers had been interchanged. -There was currently no system in place to ensure glucometers were not shared between multiple residents. Interview on 12/15/15 at 1:01 pm with the Health and Wellness Director (HWD) revealed: -She did not know whether or not the glucometers used by the facility were approved for use on multiple residents. -The facility assigned individual glucometers to each individual resident receiving FSBS testing. -The MAs were supposed to clean the glucometers before and after each use with a disinfectant wipe, then let the glucometer air dry for about two minutes. -There was currently no system in place to ensure glucometers were not shared between multiple residents.	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal041062	A. BUILDING: _____ B. WING _____	12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LAWNDALE PARK	4400 LAWNDALE DRIVE GREENSBORO, NC 27455

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D932	Continued From page 26 On 12/17/15, the Executive Director submitted the following Plan of Protection: -All glucometers were replaced immediately. -All Medication Aides would be trained on expectations of dedicated glucometers and appropriate cleaning prior to their next scheduled shift. -Glucometer readings would be verified daily for 30 days, then weekly thereafter, to ensure ongoing compliance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2016.	D932		