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CARILLON ASSISTED LIVING OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 8/2/17 and 8/3/17.	D 000		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure the electronic medication administration records (EMARs) which recorded the finger stick blood sugar (FSBS) readings were accurate, that the recorded blood sugar readings matched each residents' individual meter FSBS histories, and that the	D 367		

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blood sugar readings were documented by the individuals who performed the FSBS task for 5 of 8 sampled residents (#6, #8, #9, #10, and #11).

The findings are:

Observation of Staff A (Medication Aide) on 8/2/17 at 10:00am revealed:
-Staff A was entering handwritten FSBS readings from a purple sheet of paper into the EMAR system.
-There were multiple readings recorded on the purple paper with names and a 3-digit number to the right of the names.
-Staff A folded the paper and placed it into her pocket.

Interview with Staff A on 8/2/17 at 10:00am revealed she was entering the FSBS results into the EMAR system that were performed by 3rd shift staff and recorded on a "purple sticky note" for all residents with "before breakfast FSBS orders"

Observation of Staff H (Medication Aide) on 8/2/17 at 10:35am revealed:
-Staff H was performing a FSBS check on Resident #6.
-Staff H then entered Resident #6's reading at 10:38 into the EMAR system which displayed an order for an 11:30am FSBS task time before the resident's meal.

Interview with Staff H on 8/2/17 at 10:40am revealed:
-All staff could take FSBS readings an hour before or after it "popped on screen" as with all medications.
-If a resident was unavailable, staff would take the FSBS when the resident was available

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whether he had eaten or not.
-Sometimes staff had to get the FSBS after meals because the staff "couldn't always get them before the meal."
-All residents arrived to the dining room for lunch at approximately 12:00pm to 12:15pm.
-Taking a resident's FSBS 90 minutes prior to lunch was acceptable practice as long as the task "popped up on the EMAR screen."

Interview with Resident #6 at 8/2/17 at 10:35am revealed:
-The resident was happy with the staff but could not understand why "they woke him up at 5:00am on 8/1/17 and 5:15am on 8/2/17" to take his blood sugar.
-Resident #6's never had his "before breakfast blood sugars" checked by first shift staff.
-All of his pre-breakfast FSBS were performed by third shift in his room since his moving to the facility on 6/17/17.
-Resident #6 would eat breakfast at 8:00am which was approximately 3 hours after his usual 5:00am finger sticks.

Interview with Staff H on 8/3/17 at 10:00am revealed:
-FSBS tasks appeared on the EMAR system each morning at 7:30am.
-First shift staff entered all of the third shift's FSBS readings into the EMAR system from the purple sheet.
-The purple paper contained all of the blood sugar readings taken by third shift which third shift provided to first shift before they left each day.
-Third shift staff all recorded FSBS on a "sticky note" which was always placed on the medication cart each day.
-This helped the first shift staff know the

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resident's blood sugars prior to giving insulin.
-First shift staff's initials showed up in the EMAR system as having been administered during the 1st shift.
-The FSBS were actually performed by third shift "usually between 6:00am to 6:30am.

Interview with Resident Care Director on 8/3/17 at 10:10am revealed:
-The third shift staff historically performed the blood sugar tasks on their shifts and recorded their results on a piece of paper on the medication cart.
-The facility had always allowed third shift staff to assist first shift staff by taking the FSBS before their end of shift.
-The first shift staff entered the results for the third shift staff in the EMAR system.
-The third shift employees had permission to enter the FSBS results into the EMAR system themselves but "that's the way the facility had always done it."
-She could not be certain what time on third shift that the FSBS were performed.
-FSBS could be performed 1 hour before and after it "popped on screen" on the EMAR system which meant as early as 6:30am.
-She was aware FSBS should be before meals and stated FSBS performed on third shift were considered before meal.
-All third shift medication aides performed this task on their shift, recorded the readings on a piece of paper on the medication cart for first shift to enter.
-The facility's policy for medications was that the medication aide that administered a medication was the same individual entering their initial into the EMAR system, however it had not been followed with FSBS.
-She was unaware that any residents were

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getting their FSBS checks prior to 6:30am.
-She was unaware that FSBS checks were to be performed 30 minutes prior to meals.
-She could not explain why the policy for medication administration was not being followed for FSBS.

Observation of Resident #6 on 8/3/17 at 8:45am revealed he was sitting at a table of 4 eating breakfast.

Interview with Resident #6 on 8/3/17 at 8:45am revealed he had not received his FSBS check before breakfast, nor when he woke up.

Review of of Resident #6's EMAR's FSBS record on 8/3/17 at 8:55am revealed:
-A 7:30am entry of "108" reading was documented on 8/3/17 with the initials of the Resident Care Director.

Observation of Resident #6's glucometer 8/3/17 at 8:56am revealed there were no entries for a 108 reading on Resident #6's meter.

Interview with Resident Care Director on 8/3/17 at 8:56am revealed:
-Her initials were the same that were entered on the EMAR.
-She had not performed nor entered FSBS on Resident #6 as entered in the EMAR.
-One of the medication aides or the third shift must have performed it and one of the first shift medication aides must have entered it under her ID as she sometimes forgot to log out.
-She did not have an explanation why the 108 reading was there when informed that Resident #6 had not had a FSBS today.
-It was the expectation of the facility staff to log out of the computer before they left for their shift.

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D 367	Continued From page 5 -It was the expectation that if a staff member failed to log out of the computer, the on-coming shift staff member would log that staff member out and log in under their own ID. 1. Review of Resident #6's current FL-2 dated 7/13/17 revealed: -Diagnoses of history of falls, coronary artery disease, cardio myopathy, diabetes mellitus, hypertension, chronic kidney disease and cardiac heart failure. -An order for finger stick blood sugar (FSBS) 4 times daily before meals and before bedtime. Review of Resident #6's blood sugar glucometer reading on 8/3/17 at 1:45pm revealed: -The glucometer's date and time was incorrect and displayed as "06-05 12:24am." -There was a history of 42 blood sugars taken from "5-29 12:45am" to "06-05 12:24am." -The blood sugar ranges were between 92 and 144. -There were orders for Levemir 7 units before bedtime and Novolog 3 units before breakfast and lunch. -There were no sliding scale insulin orders. Review of Resident #6 EMAR FSBS documented readings between 7/24/17 and 8/3/17 and glucometer memory histories revealed: -There were 21 of the 42 results recorded in the glucometer which did not correspond to the entries on the EMAR. -The glucometer's time stamp was not programmed and all readings did not correspond with the EMAR time entries. -The 21 undocumented glucometer results were not among the entries, nor the facility's other 7 diabetic residents' EMAR entries.	D 367		

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D 367	Continued From page 6 Refer to interview with an onsite Medication Aide (MA) on 8/3/17 at 5:39pm. Refer to interview with a third MA on 8/03/17 at 3:00 pm. Refer to interview with Staff G on 8/3/17 at 5:35pm. Refer to interview with the Director of Clinical Operations and Risk Management on 8/3/17 at 3:34pm. Refer to interview with the Regional Director of Operations on 8/3/17 at 3:45pm. Refer to interview with the facility's physician on 8/3/17 at 4:05pm. 2. Review of Resident #8's current FL-2 dated 9/9/16 revealed: -Diagnoses of hyponatremia, hypertension, arthritis, hypothyroidism, pyuria, vertigo, glaucoma, abdominal pain and nausea and vomiting. -An order for finger stick blood sugar (FSBS) once per week. -There were no orders for insulin. Review of Resident #8's blood sugar glucometer on 8/3/17 at 1:45pm revealed: -The glucometer's date and time was incorrect and displayed as "1-12 11:12am." -There was a history of 2 blood sugars in the glucometer memory of 71 and 271. Review of Resident #8 documented FSBS on the EMAR between 71/17 and 8/3/17 and glucometer memory histories revealed: -The 2 results recorded in the glucometer did not	D 367		

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match the 5 weekly entries on the EMAR.
-The 5 entries recorded in the EMAR system were 122, 118, 122, 118 and 496.
-The 2 undocumented glucometer results were not among the EMAR entries for the other 7 diabetic residents' EMAR entries.

Interview with Resident #8 on 8/03/17 at 2:40 p.m. revealed:
-The staff wore gloves when they checked his blood sugars.
-He had not seen his blood sugar meter in a bag.
-Staff check his blood sugars after meals.
-His blood sugars are checked once a week.
-No one checked his blood sugars before breakfast.
-He did not remember night staff on third shift checking his blood sugars.
-He thought something was wrong with either the facility's glucometer or the hospital's glucometer as such drastically different readings should not occur within a few minutes of a resident's FSBS.
-He was not sure if he received a new blood sugar meter after returning from the hospital.
-He did not think he had issues with his blood sugars because he was not a diabetic.
-He did not know why his doctor wanted his blood sugar checked weekly.

Refer to interview with an onsite Medication Aide (MA) on 8/3/17 at 5:39pm.

Refer to interview with a third MA on 8/03/17 at 3:00 pm.

Refer to interview with Staff G on 8/3/17 at 5:35pm.

Refer to interview with the Director of Clinical Operations and Risk Management on 8/3/17 at

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D 367	Continued From page 8 3:34pm. Refer to interview with the Regional Director of Operations on 8/3/17 at 3:45pm. Refer to interview with the facility's physician on 8/3/17 at 4:05pm. 3. Review of Resident #9's current FL-2 dated 10/10/16 revealed: -Diagnoses of type 2 diabetes, compression fractures, hypertension, below knee amputation, orbital mass, hyperlipidemia, malign neoplastic prostate, allergic rhinitis, anemia, vitamin D deficiency and an inguinal hernia. -An order for finger stick blood sugar (FSBS) 2 times daily before breakfast and before supper. -There was an order for Lantus 5 units before bedtime. -There were no sliding scale insulin orders. Review of Resident #9's blood sugar readings on the glucometer on 8/3/17 at 1:45pm revealed: -The glucometer's date and time was incorrect and displayed as "05-23 07:12pm" -There was a history of 27 blood sugars in the glucometer memory between "05:20 12:30pm and 06-05 12:44pm." -The blood sugar ranges were between 79 and 170. Review of Resident #9 EMAR FSBS readings between 7/21/17 and 8/3/17 and glucometer memory histories revealed: -There were 7 of the 27 results recorded in the glucometer which did not match the entries documented on the EMAR. -The glucometer's time stamp was not programmed and all readings did not correspond with the EMAR time entries.	D 367		

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D 367	Continued From page 9 -The 7 undocumented glucometer results were not among the facility's other 7 diabetic residents' EMAR entries or glucometers. Refer to interview with an onsite Medication Aide (MA) on 8/3/17 at 5:39pm. Refer to interview with a third MA on 8/03/17 at 3:00 pm. Refer to interview with Staff G on 8/3/17 at 5:35pm. Refer to interview with the Director of Clinical Operations and Risk Management on 8/3/17 at 3:34pm. Refer to interview with the Regional Director of Operations on 8/3/17 at 3:45pm. Refer to interview with the facility's physician on 8/3/17 at 4:05pm. 4. Review of Resident #10's current FL-2 dated 8/13/16 revealed: -Diagnoses of diabetes, dementia, history of breast cancer, chronic back pain, diabetic neuropathy, anxiety, depression and history of stroke. -An order for finger stick blood sugar (FSBS) 4 times daily before meals and at bedtime. -There was an order for Humilog 18 units three times daily. -There were no sliding scale insulin orders. Review of Resident #10's blood sugar glucometer on 8/3/17 at 1:45pm revealed: -The glucometer's date and time was incorrect and displayed as "01-01 02:22pm" -There was a history of 54 blood sugars in the	D 367		

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glucometer memory between "01-01 02:22pm and 01-01 03:02pm"
-The blood sugar ranges were between 79 and 170.

Review of Resident #10 EMAR FSBS readings between 7/21/17 and 8/3/17 and glucometer memory histories revealed:
-There were 49 of the 54 results recorded in the glucometer which did not match the entries documented on the EMAR.
-The glucometer's time stamp was not programmed and all readings did not correspond with the EMAR time entries.
-The 49 undocumented glucometer results were not among the facility's other 7 diabetic residents' EMAR entries.

Refer to interview with an onsite Medication Aide (MA) on 8/3/17 at 5:39pm.

Refer to interview with a third MA on 8/03/17 at 3:00 pm.

Refer to interview with Staff G on 8/3/17 at 5:35pm.

Refer to interview with the Director of Clinical Operations and Risk Management on 8/3/17 at 3:34pm.

Refer to interview with the Regional Director of Operations on 8/3/17 at 3:45pm.

Refer to interview with the facility's physician on 8/3/17 at 4:05pm.

5. Review of Resident #11's current FL-2 dated 1/12/17 revealed diagnoses included hypertension, cerebral vascular accident and

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D 367	Continued From page 11 neutropenia. Review of a document titled "Report of Health Services to Residents" for Resident #11 dated 6/17/17 revealed a Primary Care Provider (PCP) order for blood glucose checks twice weekly and contact the PCP if over 200 or under 70. Review of Resident #11's glucometer on 8/3/17 at 2:40pm revealed: -The glucometer's date and time was incorrect and displayed as "05-26 at 02:56am" -There was a history of nine blood sugar results in the glucometer memory between "04-28 at 08:13pm and 05-19 at 06:41pm." -The blood sugar ranges were between 74 and 338. Review of Resident #11's July and August 2017 FSBS results documented on the EMAR revealed there was an entry for checks twice weekly with seven results ranging from 74 - 156 documented between 7/14/17 and 8/3/17. Review of FSBS results documented on Resident #11's EMAR between 7/14/17 and 8/3/17 and glucometer memory revealed: -There were two FSBS results documented on the EMAR that were not in the glucometer and there were two results recorded in the glucometer history that were not documented on the EMAR. -The most recent FSBS result in the glucometer was 88 dated 05-19 at 06:41pm which corresponded to a FSBS result documented on the EMAR for 7/28/17 between 7:00am and 3:00pm. -There was no result in the glucometer for the FSBS result of 156 documented on the EMAR for 8/1/17 between 7:00am and 3:00pm. -There was a FSBS result for 75 in the	D 367		

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glucometer dated 05-16 at 06:12pm which corresponded to a FSBS result documented on the EMAR for 7/25/17 between 7:00am and 3:00pm.
-There was no result in the glucometer for the FSBS result of 122 documented on the EMAR for 7/21/17 between 7:00am and 3:00pm.
-There was a FSBS result for 81 in the glucometer dated 05-10 at 08:18pm that did not have a corresponding FSBS result documented on the EMAR.
-There was a FSBS result for 78 in the glucometer dated 05-09 at 06:17pm which corresponded to a FSBS result documented on the EMAR for 7/18/17 between 7:00am and 3:00pm.
-There was a FSBS result for 338 in the glucometer dated 05-08 at 08:43am that did not have a corresponding FSBS result documented on the EMAR.
-There was a FSBS result for 190 in the glucometer dated 05-05 at 11:03pm which corresponded to a FSBS result documented on the EMAR for 7/14/17 between 7:00am and 3:00pm.

Interview with Resident #11 on 8/03/17 at 3:42 p.m. revealed:
-Her blood sugar meter was kept in a red bag.
-She was not sure her meter in the red bag was used each time staff checked her blood sugars.
-Staff wore gloves when they checked her blood sugars.
-The third shift facility staff checked her blood sugars but she was not aware of what time of the morning the FSBS checks were performed.
-Her blood sugars were checked randomly sometimes 2-3 times a week, after meals, and later in the day.

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CARILLON ASSISTED LIVING OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

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D 367	Continued From page 13 Interview with the Resident Care Coordinator (RCC) on 8/3/17 at 3:06pm revealed: -The initials documented for the 8/1/17 FSBS result of 156 belonged to her. -The 1st shift MA entered the result. -The RCC must have forgotten to sign out of the computer and her initials were entered for the FSBS result. Telephone interview with the 1st shift MA on 8/3/17 at 5:27pm revealed: -She did not complete a blood sugar check for Resident #11 or any other resident for the morning blood sugar checks on 8/1/17. -The 3rd shift MA completed the morning blood sugar checks, including Resident #11, and wrote the results on a sticky note which was left on the medication cart. Refer to interview with an onsite Medication Aide (MA) on 8/3/17 at 5:39pm. Refer to interview with a third MA on 8/03/17 at 3:00 pm. Refer to interview with Staff G on 8/3/17 at 5:35pm. Refer to interview with the Director of Clinical Operations and Risk Management on 8/3/17 at 3:34pm. Refer to interview with the Regional Director of Operations on 8/3/17 at 3:45pm. Refer to interview with the facility's physician on 8/3/17 at 4:05pm. _____ Interview with an onsite Medication Aide (MA) on	D 367		

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D 367	Continued From page 14 8/3/17 at 5:39pm revealed: -The 3rd shift MA did not enter the FSBS result on the EMAR, they only communicated the results to the next shift by writing each of the residents' names and their FSBS results on a sticky note which was left on the medication cart for first shift to enter. -The FSBS results were communicated this way because a resident might have a FSBS result that was out of range for them to get their morning insulin. -There were a few residents who had orders to hold their insulin if their FSBS was less than 100. -She had not recorded a FSBS result for Resident #11, so she did not know how the results were documented. Interview with a third MA on 8/03/17 at 3:00 pm. revealed: -She checked six residents' blood sugars on third shift. -She entered two residents' blood sugars in the EMAR as completed on third shift. -She recorded the residents' blood sugars on a note pad and left on the medication cart for first shift staff to enter into the computer system. -She left the handwritten notes with the residents' names and blood sugar readings taken on third shift on the medication cart for first shift because that was what they were asked to do to help out first shift staff. -She was unaware of the facility policy on FSBS but the practice of third shift performing the fingersticks and first shift documenting the fingersticks had been going on for approximately two years. Interview with Staff G on 8/3/17 at 5:35pm revealed: -Staff G was a medication aide and often worked	D 367		

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D 367	Continued From page 15 third shift. -Third shift would take the resident FSBS towards the end of their shift which ended at 7:00am daily. -The FSBS results were written on a piece of paper for first shift so the first shift would be aware of the insulin needs before the residents went to breakfast. -Third shift had never entered the FSBS results into the EMAR although they had the ability. -The facility's protocol was for third shift to record the results on paper and first shift would enter them into the system "when the blood sugars popped on screen" in the EMAR system at 7:30am. -Blood sugars were usually checked after 6:30am am. This had been the practice for the last two years. -Staff G could not explain why the glucometers' histories did not reflect the entries documented on the EMAR. -Each resident had their own glucometer in their own zipper bags and the glucometers were never used on other residents. Interview with the Director of Clinical Operations and Risk Management on 8/3/17 at 3:34pm revealed: -He was a registered nurse who performed all staff training at the facilities. -The facility's policy was that the person performing the FSBS would enter the results in the EMAR. -He was unaware that the third shift staff were performing the FSBS and the first shift staff were accepting third shift's handwritten FSBS results and entering those results in the EMAR system under their own IDs. -He would be retraining all staff that take FSBS readings to enter those readings themselves. -He would be retraining all staff on proper	D 367		

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cleaning of the meters.
-The handwritten paper recording of the third shift staff would cease and all orders would be recorded by the staff who performed those orders.
-He was unaware that the glucometers were not programmed and did not reflect the recorded blood sugars on the EMAR system.
-He was issuing all new glucometers today (8/3/17).

Interview with the Regional Director of Operations on 8/3/17 at 3:45pm revealed:
-She could not explain why the meters and the EMAR entries were not the same.
-She was ultimately responsible for ensuring systems were in place to ensure glucometer results were recorded correctly and in a timely manner.
-All residents had been issued new glucometers as of today (8/3/17).
-All staff were currently in training related to FSBS, proper cleaning of the glucometers, proper recording of the results and to ensure FSBS were taken before meals at the appropriate time specified by the physician's orders.

Interview with the facility's physician on 8/3/17 at 4:05pm revealed:
-His expectations were that the medication aides would use one meter, one lancet and one strip on each resident.
-He received a phone call from the facility on 8/2/17 related to a 496 blood sugar reading on Resident #8 necessitating an emergency room visit.
-The facility had informed him of a 496 blood sugar reading at approximately 7:30am on 8/2/17.
-He was unaware that when Emergency Medical Services arrived at 7:45am on 8/2/17 that the

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D 367	Continued From page 17 FSBS reading was 97. -He was concerned of the accuracy of the facility's glucometers stating that he could have easily ordered a bolus of insulin which could have put Resident #8 in a coma. -He had no explanation of the variance in FSBS readings between the facility and the emergency medical providers but suggested that the facility needed to calibrate their meters. -He based his diabetic treatment off consistency and proper timing of the blood sugar checks. -He would discuss this issue with the director of the facility when he visited next week. -Someone at the facility had to figure out why the readings are "all over the place". -At this time there are no issues with diabetic care related to the residents other than the 496 blood sugar reading which proved to be inaccurate for Resident #8. -He would personally oversee that the process of taking FSBS at the facility to ensure they were performed correctly and at the appropriate times. _____ The failure of the facility to ensure the accuracy of the 5 residents' FSBS results as well as ensuring that the staff performing the FSBS were entering the correct results into the EMAR was detrimental to the health, safety and welfare of the residents. The facility's medical provider and staff relied on accurate FSBS results to determine proper insulin dosages for the 8 diabetics at the facility. This constitutes a B violation. _____ Review of the facility's Plan of Protection dated 8/3/17 revealed: -All medicaion aides would be retrained on the 6 Rights of Medication Administration. -All medication aides would be inserviced on	D 367		

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D 367	Continued From page 18 proper documentation practice to include the same medication aide performing a finger stick would also be the one to enter the findings into the EMAR system. -The RCC and/or RCD would conduct random medication pass observations to ensure proper processes and procedures are being followed at the facility. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 17, 2017	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medications and infection prevention. The findings are: 1. Based on observation, interview, and record review, the facility failed to assure the electronic medication administration records (EMARs) which recorded the finger stick blood sugar (FSBS) readings were accurate, that the recorded	D912		

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D912	Continued From page 19 blood sugar readings matched each residents' individual meter FSBS histories, and that the blood sugar readings were documented by the individuals who performed the FSBS task for 5 of 8 sampled residents (#6, #8, #9, #10, and #11). [Refer to Tag 367 10A NCAC 13F .1004(j) Medication Administration (Type B Violation)] 2. Based on observations, interviews, and record reviews, the facility failed to maintain infection control procedures to prevent the transmission of blood borne pathogens as evidenced by shared glucometers for 2 of 8 sampled residents (#12 and #13) with Physician orders for blood glucose monitoring. [Refer to Tag 932 G.S.131D-4.4A(b) Adult Care Home Infection Prevention Requirements (Type B Violation)]	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection 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		

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D932	Continued From page 20 c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to maintain infection control procedures to prevent the transmission of blood borne pathogens as evidenced by shared glucometers for 2 of 8 sampled residents (#12 and #13) with Physician orders for blood glucose monitoring. The findings are:	D932		

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D932	Continued From page 21 Observation on 8/3/17 at 11:45am revealed the glucometer with Resident #12's name was in the bag labeled with Resident #13's name; and the glucometer for Resident #13 was in the bag labeled with Resident #12's name. 1. Review of Resident #12's current FL-2 dated 3/28/17 revealed diagnoses included diabetes mellitus and coronary artery disease. Review of a Physician's order for Resident #12 dated 4/4/17 revealed an order for blood glucose checks three times daily. Review of Resident #12's glucometer on 8/3/17 at 11:45am revealed: -The glucometer's date and time was incorrect and displayed as "01-01 at 05:48pm." -There was a history of 19 blood sugar results in the glucometer memory between "07-14 at 04:30am and 08-02 at 05:48pm." -The blood sugar results were recorded in mmol/l (millimoles per liter) instead of mg/dl (milligram per deciliter) and ranged from 5.6 to 13.6; converted the results ranged from 101 - 245. Interview with a Medication Aide (MA) on 8/3/17 at 5:39pm revealed she had not recorded a FSBS result for Resident #12, so she did not know how the results were calculated and documented. Review of Resident #12's July and August 2017 electronic Medication Administration Record (EMAR) revealed: -There was an entry for FSBS (Finger Stick Blood Sugar) checks three times daily with 23 results documented ranging from 88 - 320 between 7/14/17 and 7/22/17. -There was documentation Resident #12 was out of the facility/in the hospital from 7/22/17 - 8/3/17.	D932		

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D932	Continued From page 22 Review of Resident #12's EMAR FSBS results documented between 7/14/17 and 8/3/17 and glucometer memory revealed none of the FSBS results recorded in the glucometer memory corresponded to the FSBS results documented on the EMAR. 2. Review of Resident #13's current FL-2 dated 3/30/17 revealed diagnoses included Diabetes Mellitus and Hypertension. Review of a Physician's order for Resident #13 dated 5/17/17 revealed an order for blood glucose checks daily. Review of Resident #13's glucometer on 8/3/17 at 11:45am revealed: -The glucometer's date and time was incorrect and displayed as "04-06 at 04:30am" -There was a history of 22 blood sugar results in the glucometer memory between "03-16 at 12:06am and 03-25 at 01:14am." -The blood sugar results ranged from 88 - 375. Review of Resident #13's July and August 2017 EMAR revealed there was an entry for FSBS (Finger Stick Blood Sugar) checks daily with 23 results ranging from 88 - 320 documented between 7/14/17 and 8/2/17. Review of Resident #13's EMAR FSBS results documented between 7/14/17 and 8/3/17 and Resident #13's glucometer memory revealed none of the FSBS results recorded in the glucometer memory corresponded to the FSBS results documented on the EMAR. _____ Review of Resident #12's glucometer history for	D932		

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D932	Continued From page 23 "07-14 at 04:30am and 08-02 at 05:48pm" and Resident #13's EMAR FSBS results between 7/14/17 and 8/3/17 revealed: -Thirteen of 19 (converted) FSBS results in Resident #12's glucometer corresponded to the FSBS results documented on Resident #13's EMAR. -Examples include: Resident #12's glucometer FSBS result of 118.8 on 08-01 at 05:49pm, and Resident #13's EMAR FSBS result of 119 on 8/2/17 at 7:30am. -Resident #12's glucometer FSBS result of 244.8 on 07-22 at 06:19pm, and Resident #13's EMAR FSBS result of 245 on 7/23/17 at 7:30am; -Resident #12's glucometer FSBS result of 127.8 on 07-17 at 05:44pm, and Resident #13's EMAR FSBS result of 128 on 7/18/17 at 7:30am. Review of Resident #13's glucometer history for "03-16 at 12:06am and 03-25 at 01:14am" and Resident #12's EMAR FSBS results between 7/14/17 and 8/3/17 revealed: -Sixteen of 22 FSBS results in Resident #13's glucometer corresponded to the FSBS results documented on Resident #12's EMAR. -Examples include: Resident #13's glucometer FSBS result of 284 on 03-25 at 01:14am, and Resident #12's EMAR FSBS result of 284 on 7/22/17 at 6:30am. -Resident #13's glucometer FSBS result of 257 on 03-22 at 06:33am, and Resident #12's EMAR FSBS result of 257 on 7/19/17 at 11:30am. -Resident #13's glucometer FSBS result of 195 on 03-20 at 11:36am, and Resident #12's EMAR FSBS result of 195 on 7/17/17 at 6:30am. -There were seven FSBS results documented on Resident #12's EMAR that were not recorded in Resident #13's glucometer memory. Telephone interview with a Medication Aide (MA)	D932		

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D932	Continued From page 24 on 8/3/17 at 5:27pm revealed: -Her initials were entered on the EMAR for the FSBS result of 195 on 7/17/17 at 6:30am for Resident #12. -She had performed the FSBS check on Resident #12 on 7/17/17 at 6:30am. -She was not aware that Resident #13's glucometer was in Resident #12's bag and had the 195 result in the glucometer's history. -She did not know how Resident #12's and Resident #13's glucometers got in the wrong bags. -She always checked the bag and the glucometer for the resident's name before checking the FSBS. -She did not know the glucometers for Resident #12 and Resident #13 were in the wrong bags until 8/3/17. -She did not know how the results documented on Resident #13's EMAR that corresponded to results in Resident #12's glucometer memory, were calculated from mmol/l to mg/dl. Interviews with two other MA's on 8/3/17 at 5:27pm and 5:39pm revealed: -If there were problems with a resident's glucometer or the batteries gave out, the MAs would take the glucometer to the Resident Care Director (RCD) and she would either replace the batteries or give the MA a new glucometer for the resident. -The residents' glucometers were cleaned with rubbing alcohol after each use. -MAs checked the bag the glucometer was in and the meter to make sure the resident's name was on it before performing FSBS checks. -Once completing FSBS checks each residents' glucometer was cleaned with rubbing alcohol and put back in the resident's bag with their name on it.	D932		

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D932	Continued From page 25 -It was not clear how Resident #12's and Resident #13's glucometers got in the wrong the bags because each residents' glucometers were kept on different medication carts. Interview with a fourth MA on 8/03/17 at 3:06 p.m. revealed: -She did not consistently perform blood sugar checks on the adult care side (AL) of the facility because she usually worked in the special care unit (SCU). -No one received blood sugar checks in the SCU. -She seldom worked on the AL side. -She was unsure of the number of residents who had their blood sugars checked on the AL side. -When she worked on the adult care unit, she used each resident's pencil bag with their own blood sugar meter in it. -She never shared the residents' blood sugar meters with another resident. -She wore gloves when assisting each resident in checking their blood sugars. Interview with a fifth MA on 8/03/17 at 3:13 p.m. revealed: -She believed there were eight residents on the adult care unit who received blood sugar checks. -She was unsure of the number of residents who were to receive blood sugar checks because of working on different medication carts on the AL side. -She used each resident's own bag when checking their blood sugars. -Every resident on the adult care unit had their own blood sugar meter kept in a zippered bag. -She had never used another resident's blood sugar meter to check another resident's blood sugar. Review of the owner's manual for glucometers	D932		

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	HAL092166	A. BUILDING: _____ B. WING _____	08/03/2017

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CARILLON ASSISTED LIVING OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	Continued From page 26 used by the facility revealed: -The meter was for single patient use only and was not intended to be used on multiple patients. -All parts of the kit were considered biohazardous and could possibly transmit infectious diseases, even after cleaning and disinfecting. Review of the facility's undated "Glucometer Protocol - Cleaning and Disinfection" on 8/3/17 revealed: -[Clean] whenever the meter and/or lancet device was visibly dirty. -[Clean] at least once per week (recommend cart audits). -[Clean] before the meter and/or lancet device were being operated by a second person. -[Clean] Whenever the reading was high or low. -Always refer to individual owner's manual on each device for accuracy and infection prevention. Interview with the Regional Director on 8/3/17 at 9:45am revealed: -She was not aware that results in residents' glucometer memories did not correspond to results documented individual EMARs. -Staff were expected to use individual glucometers which were labeled with each residents' name. Observation on 8/3/17 at 10:15am revealed there were three new glucometer kits in unopened boxes stored in the Resident Care Director's (RCD's) office. Interview with the RCD on 8/3/17 at 10:15am revealed: -Staff were expected to use individual glucometers labeled with the residents' name. -There was no reason for staff to ever share a	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D932	Continued From page 27	D932		

glucometer between residents.
-If a resident's glucometer was not working, there were brand new glucometers kept in the storage closet.
-Staff did not have direct access to the storage closet, but they could come to the RCD and get a new glucometer or new batteries if needed.

Interview with the Director of Clinical Operations and Risk Management on 8/3/17 at 3:34pm revealed:
-He was a registered nurse who performed all staff training at the facilities.
-He would be retraining all staff on proper cleaning of residents' glucometers.
-He was issuing all new glucometers today (8/3/17).

Interview with the Regional Director on 8/3/17 at 3:35pm revealed:
-Prior to 8/3/17, the MAs used rubbing alcohol to clean the residents' glucometers weekly.
-Staff were expected to use individual glucometers for residents; glucometer's were not to be shared.
-She could not explain why the meters and the EMAR entries were not the same.
-There was no prior system in place of reviewing FSBS results in glucometers and assuring accuracy of results that were documented on residents' EMARs.
-All residents had been issued new glucometers as of today (8/3/17).
-All staff were currently in training related to FSBS, proper cleaning of the glucometers, proper recording of the results and to ensure FSBS were taken before meals at the appropriate time specified by the physician's orders.
-The cleaning protocol was in effect prior to 8/3/17 and would be revised based on

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D932	Continued From page 28 recommendations from a quality assurance review and would include manufacturer instructions for use and cleaning. _____ The facility's practice of sharing glucometer's and failure to monitor and maintain strict adherence to individual glucometer use to prevent the spread of blood borne infections for Resident #12 and Resident #13 was detrimental to the health and safety of residents, which constitutes a Type B Violation. _____ Review of the Plan of Protection submitted by the facility on 8/3/17 revealed: -Every resident on FSBS monitoring will receive a new glucose meter on 8/3/17. -All MAs will be in-serviced on proper infection control techniques as it relates to FSBSs prior to the next MA's assigned shift and no later than 8/6/17. -The RCC and/or RCD will conduct weekly medication cart audits to include glucometer checks and conduct random readings to validate accuracy on EMAR. -The RCC and/or RCD will conduct weekly monitoring on each glucometer machine for the individual resident assigned per manufacturer's information/recommendation on the control policy to ensure accuracy and infection prevention. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 17, 2017.	D932		