Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049029	A. BUILDING: _____ B. WING _____	R 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHURCHILL	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on January 23 - 26, 2018.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the 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, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 7 sampled residents (Resident #7) was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #7's current FL2 dated 7/8/17 revealed diagnoses included diabetes mellitus type 2, memory deficient, hypertension, coronary artery disease, hyperlipidemia, and arthritis. Review of Resident #7's Resident Register revealed he was admitted to the facility on 5/31/13.	D 234	Resident had the TB test re-administered 1/30/18 negative results and step to be administered 2/19/18	~~1/30/18~~ JF ~~2/19/18~~ JF

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Harold McManus | TITLE: Executive Director | (X6) DATE: 2-16-18

Reviewed and accepted with Revisions 5/9/18 JFinch / JF

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to Rule D 234 – 10A NCAC 13F .0703: Tuberculosis Test, Medical Examination & Immunizations

This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure that 1 of 7 sampled residents (Resident #7) was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services.

- Completion date for items relative to our POC will be no later than 3/12/2018. ✓

B. With Respect to How the Facility took Correction Action:

- The facility Health & Wellness Director re-administered the 1st step of TB test for this resident with negative results posted on 1/30/2018. The 2nd step was administered by Health & Wellness Director on 2/18/18 and negative results posted on 2/20/18.
- The facility conducted a medical records audit for all residents to ensure that each medical record has a record of negative TB test result or a negative chest x-ray. This was completed on 3/12/2018.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- Facility is now requiring that all licensing paperwork, including tuberculin screening results or negative chest x-rays to be submitted to the community prior to resident moving into the community.
- As facility records are thinned, documentation of the tuberculin testing will NOT be thinned and remain in the medical record.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- The Executive Director or his/her designee will be responsible for ensuring that all tuberculin screening results or negative chest x-ray results are submitted to the community prior to resident moving into the community. Ideally, this paperwork will be submitted at the time the residency agreement is being executed, which is normally 48 hours prior to admission.

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D 234	Continued From page 1 Review of Resident #7's immunization history revealed: -There was documentation of a TB test dated 4/20/15 with negative results documented on 4/22/15. -There was a TB Surveillance Questionnaire for symptoms of TB dated 6/1/16 for Resident #7. -There was a second TB Surveillance Questionnaire for symptoms of TB dated 10/4/17 for Resident #7. -There was no documentation of any other TB skin tests for Resident #7 found in the record. Interview on 1/26/18 at 1:50 pm with the Health and Wellness Director (HWD) revealed: -The HWD starting working at the facility one year ago (early 2017). -Currently, the HWD verified the status of a resident's TB test for 2 step compliance upon admission to assure compliance with the TB requirements. -The HWD was responsible for administering TB tests to new residents and documenting both the administration and the test results in the residents' medical records. -Resident #7 had been at the facility longer than the current owners had owned the facility. -Many of the residents' records had been thinned and placed in unlabeled boxes in a storage room. -She was unable to locate TB test results prior to 04/22/15 for Resident #7. Interview on 1/26/18 at 2:12 pm with the Resident Care Coordinator (RCC) revealed: -The HWD and the Clinical Coordinator (nurses) were responsible for assuring residents were compliant with the TB requirements. -She was not aware Resident #7 did not have documentation for 2 step TB testing on file.	D 234		

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D 234	Continued From page 2 Interview with the Business Office Manager (BOM) on 1/26/18 at 2:14 pm revealed: -The previous owners had some information on file for residents that she had maintained in the business office. -Some residents had copies of older FL2s and admission information. -Resident #7 did not have documentation of any TB test results available for review in the business office files. Interview on 1/26/17 at 3:00 pm with the Administrator revealed: -He was not aware residents did not have all the required documentation for TB testing. -The HWD and clinical nurses were responsible for assuring compliance with TB test requirements.	D 234		
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,	D 367		

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D 367	Continued From page 3 (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: Based on observations, record reviews, and interviews, the facility failed to assure the electronic Medication Administration Records (eMARs) were accurate for 1 of 7 sampled residents (Resident #6) regarding ipratropium/albuterol nebulizer solution. The findings are: Review of Resident #6's current FL2 dated 7/19/17 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, dementia, and pacemaker placement. Review of Resident #6's physician orders revealed there was a signed physician's order dated 1/4/18 for albuterol-ipratropium (3mg/3ml) inhalation solution, used to treat COPD, administer every 2 hours as needed for shortness of breath secondary to COPD. Review of Resident #6's eMAR for January 2018 revealed: -There was an entry for albuterol sulfate solution (2.5 mg/3ml), 3 ml inhale via nebulizer every 2 hours as needed for shortness of breath. -The medication had not been documented as administered for the month of January. Review of medications on hand for administration for Resident #6 on 1/25/18 revealed a box of 30 albuterol-ipratropium (3mg/3ml) solution vials	D 367		

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D 367	Continued From page 4 dispensed on 1/5/18, with one pack opened and containing 3 out of 5 vials. Interview on 1/25/18 at 9:55 am with a medication aide (MA) revealed: -The albuterol-ipratropium solution was administered on an as needed basis. -She did not think the solution had been administered at all since being prescribed. -The eMAR did not show the medication being administered for the month of January. -She had never administered a nebulizer treatment to Resident #6. -She did not know why the box of albuterol-ipratropium solution was opened or missing 2 vials of solution. Interview on 1/25/18 at 11:11 am, with a representative for the contracted pharmacy provider revealed: -The pharmacy received an order by fax for albuterol-ipratropium (3mg/3ml) on 1/4/18 and filled the order on 1/5/18. -The facility staff, and not the pharmacy staff, entered medications on the eMAR. -The pharmacy did not have an order for albuterol (2.5mg/3ml) inhalation solution on file for Resident #6. Interview on 1/25/18 at 11:58 am with the Health and Wellness Director (HWD) revealed: -A Resident Care Coordinator (RCC) was responsible for entering orders into the eMAR on second shift. -The Supervisor on third shift then performed a "second check" with the facility's "order tracker." -The HWD did a monthly audit of the eMAR but did not reconcile against the resident's records or orders because the second check was supposed to catch any errors.	D 367		

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A. With Respect to Rule D 367 – 10A NCAC 13F. 1004(i): Medication Administration

This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure the electronic Medication Administration Records (eMars) were accurate for 1 of 7 sampled residents (resident #6) regarding ipratropium/albuterol nebulizer solution.

- Completion date for items relative to our POC will be no later than 3/12/2018.
- With Respect to the Specific Staff Members Cited: Health & Wellness Director immediately in-serviced each staff member and they were educated on medication ordering/administration as ordered by the licensed prescribing practitioner on 1/29/18.

B. With Respect to How the Facility took Correction Action:

- The Health & Wellness clarified the order and corrected the entry in the eMAR immediately.
- The Health & Wellness Director conducted an in-service with all Medication Technicians & Resident Care Coordinators on 1/29/18. Medication technicians & RCC's were reeducated on medication administration according to licensed prescribing practitioner,

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- MARS for all new orders will be compared to the physicians order DAILY by the Resident Care Coordinator and the evening Supervisor in Charge.
- MARS will be compared to the physicians order and reviewed for accuracy monthly by the Health & Wellness Director or his/her designee.
- Health & Wellness Director or his/her designee to review eMar exceptions weekly.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- The status of medication administration will be reviewed monthly by the Resident Care Coordinator and Health & Wellness Director. The Quality Improvement Team will review the effectiveness quarterly during our Quality Improvement meetings.

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D 367	Continued From page 5 -The order for albuterol sulfate had been marked as verified in the facility's computer system by two separate staff as expected for the "second check" system. Telephone interview on 1/25/18 at 3:36 pm with Resident #6's family member revealed: -Resident #6 had COPD and was on continuous oxygen, as well as inhaled medications as needed for shortness of breath. -The resident had been prescribed an inhalation solution at discharge from a hospital stay on 1/4/18 for pneumonia. -He was not sure the exact name of the medication but the facility had a copy of the discharge medications in the resident's record. Based on observation and record review, it was determined that Resident #6 was not interviewable. A second interview on 1/26/18 at 9:15 am with the HWD revealed: -The eMAR had been edited to reflect the correct order for albuterol-ipratropium solution (3mg/3ml). -Resident #6 had not been administered the medication at all since it was prescribed. -She had verified with the pharmacy representative that the medication on hand was the correct medication.	D 367	Order Corrected on the MAR to match original physician's order Hackis JF	
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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A. With Respect to Rule D 912 – G.S. 131D-21(2): Declaration of Residents Rights

This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to adult care home infection prevention requirements.

- Completion date for items relative to our POC will be no later than 3/12/2018.

A. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control & Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 3 residents (#7, #9, and #10) with orders for blood sugar monitoring resulting in the shared use of glucometers.

B. With Respect to How the Facility took Correction Action:

- Completion date for items relative to our POC will be no later than 3/12/2018.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- Glucometers in question were disposed of and those residents all received their own personal glucometer on 1/23/18.
- Glucose Monitoring Policy was presented to community and Health & Wellness Director trained all Med Techs and Resident Care Coordinators regarding the proper infection control policies of how to used Glucometers. These policies and procedures meet the federal Center of Disease Control & Prevention guidelines. (see attached)

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- Weekly glucometer checks for will be conducted Resident Care Coordinators or Health & Wellness Director.
- All new Med Techs will receive Diabetic Management Training upon hire and this training will include the policy in "How to Properly Conduct Blood Glucose Monitoring". This training will be conducted by the Health & Wellness Director, Registered Nurse or Licensed Pharmacist.
- Med Techs will receive Diabetic Management Training annually and this training will also include the policy in regards to "How to Properly Conduct Blood Glucose Monitoring". This training will be conducted by the Health & Wellness Director, Registered Nurse or Licensed Pharmacist.

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D912	Continued From page 6 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure every resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations, related to adult care home infection prevention requirements. The findings are: Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 3 diabetic residents sampled (#7, #9, and #10) with orders for blood sugar monitoring resulting in the shared use of glucometers. [Refer to Tag 932, G.S. 131D-4.4A, 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	D932		

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D932	Continued From page 7 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, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION	D932		

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D932	Continued From page 8 Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 3 diabetic residents sampled (#7, #9, and #10) with orders for blood sugar monitoring resulting in the shared use of glucometers. The findings are: Observation of the front hall second floor medication cart on 1/23/18 at 11:35 am revealed: -There were 4 black glucometer cases located on the medication cart. -Two of the black glucometer cases were labeled with residents' names and contained Brand A glucometers with one glucometer not labeled with a resident's name, and one glucometer labeled with a resident's name corresponding to the resident's name on the black vinyl pouch. -One of the black glucometer cases was labeled with a resident's name (#7) and contained the Brand B glucometer labeled with a different resident's name. -The fourth black glucometer pouch was labeled with a resident's name (#7) and contained a Brand C glucometer labeled with the corresponding resident's (#7) name that was missing the battery cover. (Resident #7 had 2 different glucometers) Review of the CDC (Center for Disease Control and Prevention) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be	D932		

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D932	Continued From page 9 cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Telephone interview on 1/23/18 at 1:35 pm with the manufacturer of the Brand C glucometer revealed the glucometer was recommended for use by a more than one person if disinfected with an Environmental Protection Agency (EPA) approved disinfecting solution that was effective for disinfecting against blood borne diseases, such as Hepatitis A, Hepatitis B, and Human Immunodeficiency Virus, and effective against tuberculosis. Telephone interview on 1/23/18 at 4:50 pm with the manufacturer of the Brand A glucometer revealed the glucometer was recommended for use by a single person and should not be shared. No disinfection procedures were recommended. Interviews on 1/23/18 at 3:30 pm and 5:15 pm with the Health and Wellness Director (HWD) revealed: -The facility policy was for each resident to have a glucometer assigned to the resident, and used only for the assigned resident. -The facility had disinfectant wipes on the medication carts for wiping down the carts, computer keyboards, blood pressure cuffs, and counter tops.. -The facility did not have a routine disinfecting schedule for glucometers. -The staff were instructed to clean and disinfect glucometers if the glucometer was visibly dirty. -The facility did not currently have a system in place to randomly audit the current FSBS value in a glucometer's history compared to the current FSBS value documented on the resident's	D932		

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D932	Continued From page 10 electronic Medication Administration Record (eMAR). -The HWD was not aware if glucometers used by residents were approved for use on more than one resident. -The facility had 4 residents receiving FSBS. -No resident had a diagnosis of a blood borne disease. 1. Review of Resident #7's current FL2 dated 7/8/17 revealed: -Diagnoses included diabetes mellitus type 2, memory deficient, hypertension, coronary artery disease, hyperlipidemia, and arthritis. -There was an order for Novolog 100 unit/ml Flexpen (a short acting insulin used to lower blood sugar), inject 8 units subcutaneously 3 times a day, check fingerstick blood sugar (FSBS) 3 times a day and contact physician if blood sugar was less than 65 or greater than 350. Hold insulin if blood sugar is less than 80. Review of Resident #7's physician orders revealed an order dated 12/5/17 continuing the order for Novolog 100 unit/ml Flexpen, inject 8 units subcutaneously 3 times a day, check fingerstick blood sugar (FSBS) 3 times a day and contact physician if blood sugar was less than 65 or greater than 350. Hold insulin if blood sugar is less than 80. Observation on 1/23/18 at 11:30 am of a finger stick blood sugar (FSBS) check revealed: -The second floor morning Medication Aide (MA) opened a black glucometer case, labeled with a resident's name, containing a Brand B glucometer labeled with a different resident's name, and obtained a FSBS check for the resident named on the glucometer pouch. -The MA used disposable gloves, an alcohol	D932		

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BROOKDALE CHURCHILL	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

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D932	Continued From page 11 swab, a new test strip, and a single use disposable lancing device to perform the FSBS. -The MA disposed of the test strip, lancing device, and alcohol wipe in the biohazard waste container affixed to the medication cart. Observation on 1/23/18 at 11:35 am of the front hall second floor medication cart revealed: -There were 4 black glucometer cases located on the medication cart. -Resident #7 had 2 glucometer cases labeled with his name. -One of the black glucometer cases was labeled with a resident's name (#7) and contained the Brand B glucometer labeled with a different resident's name. -The other black glucometer pouch was labeled with a Resident #7's name and contained a Brand C glucometer labeled with Resident #7's name that was missing the battery cover. Review of Resident #7's January 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novolog 100 unit/ml Flexpen, inject 8 units subcutaneously 3 times a day, check FSBS 3 times a day and contact physician if blood sugar was less than 65 or greater than 350. Hold insulin if blood sugar is less than 80 was listed. -FSBS were scheduled at 8:00 am, 12:00 pm, and 5:00 pm daily. Review of Resident #7's Brand C glucometer's history revealed FSBS values recorded in the glucometer's history compared to values documented on Resident #7's January 2018 eMAR from 1/8/18 to 1/18/18 were consistent for values documented on the eMAR. There were no additional FSBS values documented in the Brand	D932		

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D932	Continued From page 12 C glucometer's history. Review of Resident #7's Brand B glucometer's history revealed FSBS values recorded in the glucometer's history compared to values documented on Resident #7's January 2018 . eMAR from 1/19/18 to 1/23/18 were inconsistent. Examples of inconsistencies were as follows: -Time and date were not set correctly. The time and date displayed on the glucometer was 1/23/18 at 9:58 am when the actual date and time was 1/23/18 at 11:35 am. -On 1/23/18, at 9:58 am, a FSBS reading of 134 matched the January 2018 eMAR on 1/23/18 at 12:00 pm, and at 4:03 am, a FSBS of 240 matched the FSBS documented on 1/23/18 at 8:00 am. -On 1/22/18, at 2:18 pm FSBS reading of 101 matched the FSBS documented on 1/22/18 at 5:00 pm; at 10:20 am, FSBS reading of 184 matched FSBS documented at 12:00 pm, with an additional FSBS reading recorded in the glucometer history on 1/22/18 at 5:55 am of 132, and at 4:39 am FSBS of 108, (not documented on Resident #7's January 2018 eMAR). -A FSBS reading of 91 was documented on the January 2018 eMAR for 1/21/18 at 5:00 pm, FSBS of 134 documented for 1/21/18 at 12:00 pm, and FSBS of 127 documented for 8:00 am; no FSBS were reading recorded in the glucometer's history corresponding to FSBS values documented on Resident #7's eMAR. -A FSBS reading of 184 was documented on the January 2018 eMAR for 1/20/18 at 8:00 am corresponded to a FSBS value recorded in the Brand B glucometer's history on 1/20/18 at 4:01 am, but no additional FSBS reading were recorded in the glucometer's history for FSBS of 146 at 12:00 pm and FSBS of 119 at 5:00 pm documented on the eMAR.	D932		

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D932	Continued From page 13 -On 1/19/18, at 5:01 am, a FSBS reading of 263 matched the FSBS documented on 1/19/18 at 8:00 am with an additional FSBS reading recorded in the glucometer history on 1/19/18 at 4:46 am of 193, not documented on Resident #7's January 2018 eMAR. There were no FSBS values of 110 at 5:00 pm and 196 at 12:00 pm documented on the eMAR found in the glucometer's history. Based on review of Resident #7's Brand B glucometer's history compared to the eMARs for January 2018, Resident #7 had 7 FSBS values documented on the eMARs and not recorded in the glucometer's history from 1/19/18 to 01/23/18. There were 3 additional FSBS values recorded in Resident #7's glucometer's history that were not documented on the resident's eMAR. Interview on 1/25/18 at 4:15 pm with Resident #7 revealed: -He was aware the medication aides (MA) were using a different glucometer lately to check his fingerstick blood sugar (FSBS). -He had seen MAs use at least 3 different glucometers. -He did not see if the glucometers were labeled with his name. -He trusted the MAs to use the proper equipment to check his FSBS. -He was aware one glucometer was not working because staff told him it was not working properly. Refer to interview on 1/23/18 at 5:20 pm with a medication aide (MA). Refer to telephone interview on 1/24/18 at 8:45 am with a medication aide/supervisor (MAS).	D932		

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D932	Continued From page 14 Refer to interview on 1/23/18 at 4:50 pm with the Administrator. 2. Review of Resident #10's current FL2 dated 7/10/17 revealed: -Diagnoses included hypertension, anxiety, depression, and Type II diabetes mellitus. -There was an order to monitor blood glucose in the morning. Call physician if fingerstick blood sugar (FSBS) was greater than 350 or less than 60. Review of Resident #10's physician orders revealed a subsequent order dated 9/14/17 to monitor blood glucose in the morning. Call physician if fingerstick blood sugar (FSBS) was greater than 350 or less than 60. Review of Resident #10's January 2018 eMAR revealed: -There was an entry to monitor blood glucose in the morning. Call physician if fingerstick blood sugar (FSBS) was greater than 350 or less than 60. -FSBS were scheduled daily at 6:30 am. Review of Resident #10's Brand A glucometer revealed: -The time and date were set accurately. -The glucometer had 8 FSBS reading recorded in the glucometer's history starting on 1/20 18 at 6:24 am through 1/23/18 at 6:44 am. - FSBS values recorded in the glucometer's history compared to values documented on Resident #10's January 2018 eMAR from 1/20/18 to 1/23/18 were inconsistent. Examples of inconsistencies were as follows: -On 1/20/18 at 6:24 am, the first FSBS reading of 169 was documented in the glucometer's history and corresponded to the FSBS value	D932		

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D932	Continued From page 15 documented on Resident #9's eMAR for 1/20/18 at 6:30 am. -On 1/20/18 at 6:19 pm, an additional FSBS reading of 115 was documented in the glucometer's history, but no corresponding value documented on Resident #9's eMAR for 1/20/18. -On 1/21/18 at 7:35 am a FSBS reading of 89 was recorded in the glucometer's history, but no corresponding value documented on Resident #9's eMAR for 1/21/18. -On 1/21/18 at 6:18 pm a FSBS reading of 91 was recorded in the glucometer's history, but no corresponding value documented on Resident #9's eMAR for 1/21/18. -On 1/21/18 at 9:14 pm a FSBS reading of 153 was recorded in the glucometer's history, but no corresponding value documented on Resident #9's eMAR for 1/21/18. -On 1/21/18 at 9:28 pm a FSBS reading of 162 was recorded in the glucometer's history, but no corresponding value documented on Resident #9's eMAR for 1/21/18. Review of the Brand B glucometer's history in the black glucometer case, labeled with a resident's name, containing a Brand B glucometer labeled with a different resident's name revealed: -Examples of consecutive FSBS values recorded in the glucometer's history from 1/01/18 to 1/19/18 at times from 3:53 am to 4:20 am matched FSBS documented at 6:30 am on Resident #10's January 2018 eMAR were as follows: on 1/19/18 (FSBS=192), on 1/16 (FSBS=122), on 1/12/18 (FSBS=141), on 1/11/18 (FSBS=159), 1/10/18 (FSBS=112), on 1/9/18 (FSBS=93), on 1/8/18 (FSBS=110). -FSBS values recorded in the glucometer after 1/19/18 did not correspond to FSBS values documented on Resident #10's eMAR from 1/20/18 to 1/23/18.	D932		

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D932	Continued From page 16 Based on review of Resident #10's Brand A glucometer's history and Brand B glucometer's history (in the black glucometer case, labeled with a resident's name, containing a Brand B glucometer labeled with a different resident's name) compared to the eMARs for January 2018, Resident #10 had 4 additional FSBS values recorded in Resident #10's Brand A glucometer's history, from 1/20/18 to 1/23/18, that were not documented on the resident's eMAR; and 12 FSBS values recorded in the Brand B glucometer's (in the black glucometer case, labeled with a resident's name, containing a Brand B glucometer labeled with a different resident's name) history from 1/2/18 to 1/19/18. Interview on 1/24/18 at 3:45 pm with Resident #10 revealed: -She does not pay attention to the type of glucometer used to check her FSBS. -Staff check her FSBS once daily, in the morning. -She was not aware of the brand name of the glucometer used to check her FSBS. Refer to interview on 1/23/18 at 5:20 pm with a medication aide (MA). Refer to telephone interview on 1/24/18 at 8:45 am with a medication aide/supervisor (MAS). Refer to interview on 1/23/18 at 4:50 pm with the Administrator. 3. Review of Resident #9's current FL2 dated 7/10/17 revealed diagnoses included hyperlipidemia, hypertension, and Type 2 diabetes mellitus. Review of Resident #9's physician orders	D932		

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D932	Continued From page 17 revealed an order dated 12/6/17 to check fingerstick blood sugar (FSBS) in the morning and at bedtime. Review of Resident #9's January 2018 electronic Medication Administration Record (eMAR) from 1/01/18 to 1/22/18 revealed FSBS were scheduled daily at 8:00 am and 8:00 pm. Review of Resident #9's Brand A glucometer, labeled with Resident #9's name, revealed: -FSBS values recorded in the glucometer's history compared to values documented on Resident #9's January 2018 eMAR from 1/06/18 to 1/22/18 were inconsistent. -Time and date were not set correctly. The date displayed on the glucometer was 3/09/17 on 1/23/18 at 1:25 pm. Examples of inconsistencies were as follows: -On 3/8/17 at 4:06 am, a FSBS reading of 184 recorded in Resident #9's glucometer matched the January 2018 eMAR on 1/22 at 8:00 pm. -On 3/5/17 at 3:38 am, a FSBS reading of 149 recorded in Resident #9's glucometer matched the January 2018 eMAR on 1/19 at 8:00 pm. -On 3/4/17 at 11:12 pm, a FSBS reading of 110 recorded in Resident #9's glucometer that matched the January 2018 eMAR on 1/19 at 5:00 pm for Resident #7 (and not recorded in the glucometer's history for Resident #7). -On 3/3/17 at 10:48 pm, a FSBS reading of 109 recorded in Resident #9's glucometer that matched the January 2018 eMAR on 1/18 at 5:00 pm for Resident #7 (and not recorded in the glucometer's history for Resident #7). -On 1/17/18 at 8:00 am, a FSBS reading of 122 was documented on the January 2018 eMAR for, but no FSBS reading recorded in Resident #9's glucometer's history.	D932		

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D932	Continued From page 18 -On 1/16/18 at 8:00 am, a FSBS reading of 76 was documented on the January 2018 eMAR for, but no FSBS reading recorded in Resident #9's glucometer's history. -On 2/27/17 at 1:32 pm, a FSBS reading of 207 was recorded in Resident #9's glucometer that matched the January 2018 eMAR on 1/14 at 6:30 am for Resident #10 (and not recorded in the glucometer's history for Resident #10). -On 2/20/17 at 1:11 pm, a FSBS reading of 173 was recorded in Resident #9's glucometer that matched the January 2018 eMAR on 1/7 at 6:30 am for Resident #10 (and not recorded in the glucometer's history for Resident #10). Based on review of Resident #9's glucometer's history compared to the eMARS from 1/6/18 to 1/22/18, Resident #9 had 9 FSBS values documented on the eMARs and not recorded in the glucometer's history; 2 FSBS values that was documented on the eMARs with corresponding FSBS values recorded in the glucometer's history of another resident (Resident #10), and 3 FSBS values that was documented on the eMARs with corresponding FSBS values recorded in the glucometer's history of another resident (Resident #7). Interview on 1/24/18 at 3:53 pm with Resident #9 revealed: -Staff checked her FSBS 2 times a day. -She did not pay attention to the type of glucometer used to check her FSBS. -Her vision was poor and she was not able to see if the glucometer was labeled with her name. Refer to interview on 1/23/18 at 5:20 pm with a medication aide (MA). Refer to telephone interview on 1/24/18 at 8:45	D932		

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D932	Continued From page 19 am with a medication aide/supervisor (MAS). Refer to interview on 1/23/18 at 4:50 pm with the Administrator. Interview on 1/23/18 at 5:20 pm with a medication aide (MA) revealed: -The facility policy was never to share a glucometer. -The MA was supposed to notify the shift supervisor if a resident did not have a functioning glucometer. -She wiped the glucometer with a disinfecting wipe anytime she used it, and allowed the glucometer to air dry for about 30 seconds before placing back in the glucometer pouch. -The HWD had done the infection control training for the MAs. -She was aware of one instance when she shared a glucometer assigned to a resident on a different resident because a glucometer was not working properly. -She was instructed by the HWD to use the glucometer for a different resident to check the FSBS of the resident whose glucometer was not working. -She was not aware only glucometers approved by the glucometer's manufacturer for sharing could be shared. -She was not aware of the instructions for listed on the facility's EPA approved disinfectant wipes for disinfecting glucometers. Telephone interview on 1/24/18 at 8:45 am with a medication aide/supervisor revealed: -She was responsible for checking fingerstick blood sugars (FSBS) for 2 residents each morning. -She routinely wiped each glucometer before and	D932		

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D932	Continued From page 20 after use with an alcohol swab. -She received training on infection prevention regarding glucometers within the last year. -The facility policy was that each resident had a glucometer assigned to the resident for checking FSBS. -She was aware of at least 2 residents that had a problem with their glucometers and she had used a different glucometer to check the residents' FSBS. The same glucometer was used on both residents after cleaning with alcohol wipes. -She had documented FSBS values on the eMARs for residents after she obtained the FSBS. -The EPA approved disinfecting wipes that the facility had were used to wipe down hard surfaces like the medication room counter tops and the top of the medication cart. -She had not used the disinfecting wipes on a glucometer. Interview on 1/23/18 at 4:50 pm with the Administrator revealed: -The Health and Wellness Director was responsible to assure the facility policy of one glucometer per resident and glucometers were not shared was enforced. -The facility policy was one glucometer assigned to a resident and no sharing glucometers between residents. -She was not aware staff were sharing glucometers between residents. The facility's failure to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines placed residents receiving finger stick blood sugar checks with glucometers at risk due to possible exposure of blood borne pathogens by the sharing of glucometers for Residents #7, #9 and	D932		

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to Rule D932 – G.S. 131D-4.4A(b): ACH Infection Prevention Requirements

This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to implement a written infection control policy consistent with the federal Centers of Disease Control & Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 3 residents (#7, #9, and #10) with orders blood sugar monitoring resulting in the shared use of glucometers.

- Completion date for items relative to our POC will be no later than 3/12/2018. ✓

A. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control & Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 3 residents (#7, #9, and #10) with orders for blood sugar monitoring resulting in the shared use of glucometers.

B. With Respect to How the Facility took Correction Action:

- Glucometers in question were disposed of immediately and those residents all received their own new personal glucometer on1/23/18.
- Weekly glucometer checks will be conducted Health & Wellness Director every Friday.
- Random monthly audits with Med Techs to ensure that the glucometers are not being shared.
- On 1/29/18 all Med Techs and Resident Care Coordinators were in-serviced relative to each resident is required to use their own personal glucometer and the procedure for obtaining a glucometer if needed.
- The facility audited to ensure that each resident had their own glucometer and labeled each one. This was completed on 1/23/18.
- NC DHSR approved Infection Control procedures have been added to our New Hire orientation and yearly refresher course for all Medication Technicians.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- Glucometer readings will be compared to the MAR weekly by the Health & Wellness Director or his/her designee.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- The status of all training and competencies will be monitored monthly by Business Office Manager.
- The Quality Improvement Team will review the effectiveness quarterly during our Quality Improvement meetings.

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D932	Continued From page 21 #10. This was detrimental to the health, safety and welfare of the residents receiving FSBS checks with glucometers and constitutes a Type B Violation. --- Review of the facility's Plan of Protection dated 1/23/18 revealed: -The facility staff will identify residents who receive fingerstick blood sugar checks with a glucometer. -The glucometers will be examined for any evidence of sharing. -Glucometers that were/are found to be shared were or will be replaced with new glucometers. -The staff are to be in-serviced immediately on the policy and procedures for fingerstick blood sugar testing. -The Health and Wellness Director (HWD) is responsible for assuring compliance and monitoring weekly for accuracy. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 12, 2018.	D932	Glucometers in question were replaced ~~1/23/18~~ JF Weekly glucometer checks every Friday to ensure that the weekly meter reading matches documented blood sugars ~~1/20/18~~ & JF	
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. (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	D935	Random monthly audit with the Med Techs to ensure that the glucometers are not being shared ~~1/23/18~~ JF Inservice for Med Techs on glucometer use ~~2/1/18~~ JF	

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

A. With Respect to Rule D 935 – G.S. 131D-4.5B(b): ACH Medication Aides ; Training and Competency

This Rule is not met as evidenced by: Based on observation, interview and record reviews, the facility failed to assure 1 of 3 medication aides sampled (Staff B) completed the 5, 10, or 15 hour medication training or had verification of previous employment before administering medication to residents.

- Completion date for items relative to our POC will be no later than 3/12/2018. ✓

B. With Respect to How the Facility took Correction Action:

- Staff member B was immediately removed from the position of Med Tech and no longer administers Medication until she has successfully completed the state mandated requirements.
- Facility now requires any new Med Tech that is hired to provide Business Office Manager with supporting documentation that they have successfully completed the 5/10/15 hour medication class.
- Business Office Manager immediately audited all employee personnel files to identify any employees that required annual competency training. This was completed on 3/12/18.
- NC DHSR approved Annual competency trainings procedures have been added to our New Hire orientation for all Med Techs.

C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern:

- An audit tool was created by the Business Office Manager for all employees to show there competencies and annual requirements. The audit tool is reviewed by the Executive Director monthly for compliance.

D. With Respect to How the Plan of Corrective Measures will be Monitored:

- The status of all training and competencies will be monitored by the Business Office Manager and reviewed monthly Executive Director. The Quality Improvement Team will review the effectiveness monthly during our quarterly Quality Improvement meetings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049029	A. BUILDING: _____ B. WING _____	R 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHURCHILL	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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
D935	Continued From page 22 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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 medication aides sampled (Staff B) completed the 5, 10 or 15 hour medication training or had verification of previous employment before administering medication to residents.	D935	We are requiring any new Med Tech hired has to give the BOM & HWD proof of attending their Med Tech Classes before they are hired	~~2/1/18~~ JF

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D935	Continued From page 23 The findings are: Review of Staff B's personnel file revealed: -Staff B was hired on 9/4/15 as a Medication Aide (MA). -She had a medication clinical skills validation completed on 09/29/15. -She had passed the medication aide test on 12/19/06. -There was no 5, 10 or 15 hour medication training on file. -There was no documentation of employment verification prior to beginning work as a MA at the facility. Interview on 1/26/18 at 4:20 pm with Staff B revealed: -Staff B had brought paperwork from her previous employer to the facility upon hire. -She thought that verification of her employment was included as part of her hiring paperwork. -She had taken the medication aide test for adult care homes and passed in 2006. -She had worked continuously as a MA since passing her test in 2006. -She did not have 5, 10 or 15 hour training required for medication aides. -She had worked for her previous employer from 2011 until her hire at this facility in 2015. -She planned to contact her previous employer to ask them to send a copy of the employment verification that she had done in 2015. Review of the December 2017 and January 2018 Medication Administration Records revealed Staff B had administered medications to the residents in the facility. Interview with the Health and Wellness Director	D935		

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D935	Continued From page 24 (HWD) on 1/26/18 at 4:30 pm revealed: -She was responsible for ensuring medication aides had all required training. -She was not aware that Staff B did not have employment verification in her employee file. -Staff B had been employed at the facility before the HWD came to the facility. -The Business Office Manager (BOM) would be responsible for keeping references or employment verification for all employees. -She had called Staff B's previous employer to request employment verification but no one was available to help her at this time. -She was going to get verification of employment sent to her on the following business day. Interview with Business Office Manager on 1/26/18 at 4:00 pm revealed: -She could not find any references or employment verification on file for Staff B. -She had contacted the corporate office to see if anything was stored there but had not received anything. -She had called Staff B's previous employer to ask for verification but the appropriate staff at the facility were not available to speak with her. Interview with the Administrator on 1/26/18 at 4:50 pm revealed: -The HWD was responsible for assuring that all medication aides had the required training. -Office staff were attempting to obtain employment verification now. -Staff B would be working as a Resident Assistant until verification was obtained. Review of the employment verification document submitted by the facility revealed: -Staff B had been employed by her previous employer from 2011 to 2015.	D935		

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D935	Continued From page 25 -Her position was listed as "Associate." -There was no documentation specifying her employment as a medication aide.	D935		

BROOKDALE
– SENIOR LIVING SOLUTIONS –

How To:
Blood Glucose Monitoring - **78**

Purpose:

To measure blood glucose for insulin administration. When providing care, associates will:

- Knock before entering the residents' apartment and identify yourself to the resident.
- Refer to Service Plan
- Adjust your approach to the activity based on the resident's level of mental alertness.
- Explain the procedure to the resident.
- Provide privacy for the resident.
- Gather equipment before starting.
- Return and or/dispose of equipment when completed.
- Document as directed and notify the nurse and/or supervisor of any concerns about the resident.

Associate Responsibility:

Licensed nurse, Certified Nursing Assistant, care staff or per state regulation

Equipment:

- gloves
- alcohol wipes
- blood glucose meter (resident-owned)
- single-use, auto-retractable lancet
- blood glucose meter testing strip
- gauze
- band aids
- sharps container

Suggested Guidelines:

1. Take items to the resident's room or to a designated procedure area. Do not carry supplies in pockets.
2. Perform procedure on a solid surface that can be disinfected or place a disposable cover on the surface to provide a barrier in the event of a blood contamination.
3. Wash hands with soap and water or using an alcohol-based hand sanitizer.

Date of Issue
Nov. 2016
Date revised
August, 2017

How To:
Blood Glucose Monitoring - **78**

4. Put on gloves and perform fingerstick using a single-use, auto-retractable lancet. Immediately discard the used lancet in an approved sharps container. Insert test strip into blood glucose meter.
5. When wearing gloves, before touching clean surfaces, change gloves that have touched objects or surfaces potentially contaminated with blood.
6. While continuing to wear gloves, complete the testing procedure by removing the test strip from the blood glucose meter and discarding it in a regular trash receptacle or sharps container.
7. Remove gloves and place them in trash receptacle.
8. Wash hands with soap and water or using an alcohol-based hand sanitizer.
9. Each resident requiring blood glucose monitoring with a blood glucose meter shall have their own device and not shared with other residents
10. There will be no penlets multi use, multi-stick devices stored in the community. Only individuals who are performing their own blood sugar monitoring can use a multi-stick device and it must be stored properly in their rooms, both storage bag and glucometer must be labeled with the resident's name.
11. Ensure the blood glucose meter is cleaned and disinfected after use according to manufacturer's recommendations and stored appropriately (i.e., in a storage case, labeled with the resident's name on both the glucometer and the case.)