STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL012001	A. BUILDING: _____ B. WING _____	12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKE LONG TERM CARE	125 CAMELLIA GARDEN STREET MORGANTON, NC 28655

(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 survey on December 4 - 5, 2018.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record records, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #3), related to giving the incorrect Lantus dose and administering Norvasc without an order. The findings are: Review of Resident #3's current FL2 dated 09/28/18 revealed diagnosis included altered	D 358		

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D 358	Continued From page 1 mental status. a. Review of Resident #3's current FL2 dated 09/28/18 revealed a physician's order for Lantus inject 30 units subcutaneously at bedtime (used to treat diabetes). Review of Resident #3's record revealed a physician's order dated 06/14/18 for Lantus inject 36 units subcutaneously every evening. Review of Resident #3's record revealed a physician's order dated 06/15/18 for Lantus inject 30 units subcutaneously at bedtime. Review of Resident #3's November 2018 medication administration record (MAR) revealed: -There was a computer generated entry for Lantus Solostar inject 36 units subcutaneously every evening scheduled to be administered at 8:00pm. -Lantus was documented as administered daily from 11/01/18 to 11/30/18. -There was a hand written entry to check finger stick blood sugar (FSBS) twice daily scheduled for 8:00am and 8:00pm. -FSBS ranged from 64 to 122 at 8:00am and 110 to 198 at 8:00pm. Review of Resident #3's December 2018 MAR revealed: -There was a computer generated entry for Lantus Solostar inject 36 units subcutaneously every evening scheduled to be administered at 8:00pm. -Lantus was documented as administered daily from 12/01/18 to 12/04/18. -There was a hand written entry to check FSBS twice daily scheduled for 8:00am and 8:00pm. -FSBS ranged from 86-108 at 8:00am and	D 358		

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D 358	Continued From page 2 119-190 at 8:00pm. Review of Resident #3's November 2018 insulin administration record revealed: -Lantus 30 units were administered daily at 8:00pm from 11/04/18 to 11/15/18. -Lantus 36 units were administered daily at 8:00pm from 11/01/18 to 11/03/18 and 11/16/18 to 11/30/18. -Lantus 36 units were administered a total of 18 times. Review of Resident #3's December 2018 insulin administration record revealed Lantus 36 units were administered daily at 8:00pm from 12/01/18 to 12/04/18. Review of facility's policy on medication administration revealed: -"When a new prescription changes the dosage or frequency of administration of a previously prescribed medication, discontinue the previous entry by writing DC'd and the date." -"Enter the new prescription as a new medication order." Observation of Resident #3's medications on hand on 12/05/18 at 12:50pm revealed: -An opened, partially used Lantus Solostar pen available to be administered to Resident #3 was stored in the medication cart. -The Lantus Solostar pen was labeled with Resident #3's name and an open date of 12/04/18. -There were 2 unopened Lantus Solostar pens dispensed on 11/30/18 available to be administered to Resident #3 in the refrigerator in the medication room. -The directions printed on the prescription label from the facility contracted pharmacy stated inject	D 358		

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D 358	Continued From page 3 36 units subcutaneously daily. Interview with Resident #3 on 12/05/18 at 3:07pm revealed: -She knew her insulin dose was adjusted during her hospital stay in June 2018. -She did not know how much insulin she had been receiving. -She had a "hard time thinking of things and completing tasks" when her blood sugar dropped. -She would have these symptoms if her blood sugar dropped below 90. -She would get this feeling between breakfast and lunch but would usually feel better when she ate lunch. -She had experienced this feeling a "couple of times this week." -"A few weeks ago," the medication aide (MA) had to bring her "some orange juice because she was feeling bad." Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 12/04/18 at 11:18am revealed: -There were 3 Lantus Solostar pens dispensed to Resident #3 on 11/11/18 and 11/30/18 with the directions inject 36 units subcutaneously every evening. -Resident #3's last physician's order for Lantus was written on 06/15/18. -The pharmacy did not have a physician's order for Lantus inject 30 units subcutaneously daily. -The pharmacy was responsible for printing and updating MARs for the facility. -The facility was responsible for faxing all physician's orders to the pharmacy for the MARs to be accurate and up to date. -The facility staff would make corrections to the MARs at the beginning of each month and send the corrections back to the pharmacy.	D 358		

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D 358	Continued From page 4 -The MARs would reflect the changes the following month. Interview with the first shift MA on 12/05/18 at 12:01pm revealed: -She knew Resident #3 was supposed to receive Lantus 30 units daily. -She had told the second shift MA that Resident #3 had an order to decrease the Lantus to 30 units daily. -The second shift MA was responsible for auditing the MARs and the medication cart monthly. -The MAs were responsible for processing new orders. -The MAs were responsible for faxing new orders to the pharmacy and making the changes on the MARs. -She did not remember Resident #3 having any recent problems with a low blood sugar. Interview with the second shift MA on 12/05/18 at 4:00pm revealed: -She knew the physician had decreased Resident #3's Lantus dose but could not remember when or the current dose. -She was responsible for comparing the previous MAR with the current MAR and sending the corrections to the pharmacy to update the MARs monthly. -She had corrected the Lantus order on Resident #3's October MAR. -She had "just missed the order in November" and did not update the MAR with the correct directions for Lantus for Resident #3. Telephone interview with Resident #3's primary care provider (PCP) on 12/05/18 at 2:38pm revealed: -Resident #3 was hospitalized for hypoglycemia (low blood sugar) in June 2018.	D 358		

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D 358	Continued From page 5	D 358		

-He had ordered to decrease Resident #3's Lantus to 30 units daily after this hospitalization.
-Resident #3 had no recent complaints of hypoglycemia.
-Resident #3 could tolerate blood sugar readings from 90 to 100 but had trouble with lower readings.
-Resident #3 could be at risk for hypoglycemia if the facility was administering more insulin than was prescribed.
-"Low blood sugar can led to the patient passing out or falling."

Refer to interview with the Administrator on 12/05/18 at 12:50pm.

b. Review of Resident #3's current FL2 dated 09/28/18 revealed no physician's order for Norvasc 10mg take 1 tablet daily (used to treat high blood pressure).

Review of Resident #3's FL2 dated 06/14/18 revealed a physician's order for Norvasc 10mg take 1 tablet daily.

Review of Resident #3's October 2018 MAR revealed:
-There was a computer generated entry for Norvasc 10mg take 1 tablet daily scheduled to be administered at 8:00am.
-Entry was crossed out and marked "d/c 9/28/18."
-Norvasc was not documented as administered from 10/01/18 to 10/31/18.

Review of Resident #3's November 2018 MAR revealed:
-There was a computer generated entry for Norvasc 10mg take 1 tablet daily scheduled to be administered at 8:00am.
-Norvasc was documented as administered daily

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D 358	Continued From page 6 from 11/01/18 to 11/30/18. Review of Resident #3's December 2018 MAR revealed: -There was a computer generated entry for Norvasc 10mg take 1 tablet daily scheduled to be administered at 8:00am. -Norvasc was documented as administered daily from 12/01/18 to 12/05/18. Observation of Resident #3's medications on hand on 12/05/18 at 12:50pm revealed: -There were 24 tablets of Norvasc 10mg available to be administered to Resident #3. -Norvasc was dispensed to Resident #3 on 11/27/18 from a physician's order written 03/09/18. Review of facility's policy on medication administration revealed "when a medication is discontinued, write DC'd and the date, make a line through the discontinued entry." Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/05/18 at 4:35pm revealed: -Norvasc was dispensed to Resident #3 on 09/25/18, 10/26/18, and 11/27/18. -He did not know Resident #3's Norvasc order was not on the current FL2. -The facility was responsible for faxing discontinuation orders to the pharmacy for the MARs to be updated. Interview with Resident #3 on 12/05/18 at 3:07pm revealed: -She did not remember having any recent problems with her blood pressure. -She had a "hard time thinking of things and completing tasks" on some days between	D 358		

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D 358	Continued From page 7 breakfast and lunch but thought it was because of her blood sugar. Interview with the first shift MA on 12/05/18 at 12:50pm revealed: -She did not know Resident #3's Norvasc was discontinued. -She did not know it was not on Resident #3's current FL2. -She had administered Norvasc to Resident #3 the morning of 12/05/18. -She could not find any recent blood pressure readings for Resident #3 in the blood pressure log for November or December. -Facility policy was for each resident to have their blood pressure checked monthly. Interview with the second shift MA on 12/05/18 at 4:00pm revealed: -Resident #3 was discharged from the hospital at the end of September 2018. -The hospital had stopped some of the mediations that Resident #3 was receiving. -She thought Resident #3's primary care physician (PCP) had restarted all medications after her hospitalization. -She thought she had received a verbal order to restart the Norvasc but did not document the order. Telephone interview with Resident #3's PCP on 12/05/18 at 2:38pm revealed: -Resident #3 should not be taking Norvasc. -Resident #3's blood pressure had "been doing fine." -Resident #3 was "at risk of passing out and falling if her blood pressure dropped too low." Refer to interview with the Administrator on 12/05/18 at 12:50pm.	D 358		

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D 358	Continued From page 8 Interview with the Administrator on 12/05/18 at 12:50pm revealed: -The MAs were responsible for faxing new physician's orders to the pharmacy. -The MAs were responsible for updating the MARs from month to month and sending the corrections to the pharmacy. -The MAs were responsible for clarifying new medication orders and medication order changes on an FL2. -She would only look at the MARs when she had to administer medications. -She had not "looked at the MARs for 2 to 3 months." The facility failed to administer medications as ordered by a physician, including giving a higher dose of insulin that increased the risk for low blood sugars and administering a blood pressure medication without an order, causing Resident #3 to be at risk for passing out or falling. The facility's failure to administer medication as ordered was detrimental to the safety, health, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/05/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 19, 2019.	D 358		

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D912	Continued From page 9	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, 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 medication administration and adult care home infection prevention requirements. The findings are: 1. Based on observations, interviews, and record records, the facility failed to administer medications as ordered by a physician for 1 of 3 sampled residents (Resident #3), related to giving the incorrect Lantus dose and administering Norvasc without an order. [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration, (Type B violation)]. 2. 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 sampled diabetic residents (#2, #3, and #4) with orders for blood sugar monitoring resulting in the	D912		

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D912	Continued From page 10 shared use of glucometers. [Refer to Tag 932 GS 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. 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.	D932		

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D932	Continued From page 11 (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement 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 sampled diabetic residents (#2, #3, and #4) with orders for blood sugar monitoring resulting in the shared use of glucometers. The findings are: Observation of the medication cart on 12/04/18 at 10:48am revealed: -There was only 1 glucometer stored on the medication cart. -The glucometer package was not labeled with a resident's name.	D932		

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D932	Continued From page 12 -The glucometer (Brand A) was labeled with the initials of Resident #3. -There was a lancing device that was not labeled stored in the glucometer packet with the glucometer. Observation on 12/04/18 at 12:56pm revealed: -There were 4 unlabeled lancing devices in the cabinet in the medication room. -There were 6 glucometers stored in the cabinet in the medication room labeled with residents' names. -There was 1 glucometer labeled with a resident's name that did not match the label on the package. -There was 1 glucometer in a package without any test strips. -There was 1 glucometer labeled as a "back up meter." 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 cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should be shared between residents. Review of the cleaning and disinfection instructions for the Brand A glucometer revealed the glucometer was intended to be used by a single person and should not be shared. The meter and the lancing device should be used by one person only and should not be shared. 1. Observation of Resident #2's fingerstick blood sugar (FSBS) check on 12/04/18 at 10:48am	D932		

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D932	Continued From page 13	D932		

revealed:
-The medication aide (MA) used a lancing device to check Resident #2's FSBS.
-The lancing device was stored in the glucometer package with the glucometer.

Observation of Resident #2's glucometer on 12/04/18 at 10:52am revealed:
-The glucometer used to check Resident #2's FSBS was labeled on the back with Resident #3's initials in small print.
-The lancing device stored in the glucometer package was unlabeled.

Review of Resident #2's current FL2 dated 06/14/18 revealed:
-Diagnoses included type 2 diabetes mellitus, hypertension, cerebrovascular accident, and anxiety.
-There was an order to perform FSBS checks three times daily and as needed.

Review of Resident #2's record revealed a physician's order dated 10/01/18 to check blood sugar before meals and at bedtime scheduled for 7:00am, 11am, 4pm and 8pm.

Review of Resident #2's November 2018 medication administration record (MAR) revealed there was an entry to check FSBS before meals and at bedtime scheduled for 7am, 11am, 4pm and 7pm.

Review of Resident #2's Brand A glucometer's history revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #2's November 2018 MAR. Example of inconsistencies were as follows:
-There was one FSBS reading that was

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(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 14	D932		

documented on the MAR that was not in Resident #2's glucometer history on 11/22/18 of 137 at 4pm.
-There were two FSBS readings that were documented on the MAR, that were not in Resident #2's glucometer history for 11/23/18, including 97 at 8am, and 120 at 4pm.
-There were two FSBS readings that were documented on the MAR, that were not in Resident #2's glucometer history for 11/24/18, including 200 at 11am, and 138 at 4pm.
-There were three FSBS readings that were documented on the MAR, that were not in Resident #2's glucometer history for 11/25/18, including 100 at 8am, 139 at 4pm, and 276 at 8pm.

Review of Resident #2's December 2018 MAR revealed there was an entry to check FSBS before meals and at bedtime scheduled for 7am, 11am, 4pm and 8pm.

Review of Resident #2's Brand A glucometer's history revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #2's December 2018 MAR. Example of inconsistencies were as follows:
-There were two FSBS readings that were documented on the MAR, that were not in Resident #2's glucometer history for 12/01/18, including 210 at 8am, and 130 at 4pm.
-There was one FSBS reading that was documented on the MAR that was not in Resident #2's glucometer history on 12/02/18 of 123 at 4pm.
-There were two FSBS readings that were documented on the MAR, that were not in Resident #2's glucometer history for 12/03/18, including 81 at 11am, and 150 at 4pm.

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D932	Continued From page 15 Interview with the first shift MA on 12/04/18 at 12:56pm revealed: -She used the same glucometer to check Resident #2's FSBS and his roommate's FSBS. -She thought it was okay to use the same glucometer since Resident #2 was related to his roommate. -She used the lancing device on the medication cart to check Resident #2's blood sugar. Interview with Resident #2 on 12/04/18 at 2:58pm revealed: -He had his blood sugar checked 4 times each day sometimes in his room and other times in the dining room before meals. -He did not know which glucometer the MA used to check his blood sugar. -He did not know what his glucometer looked like. -The MA used individual safety lancets until "about a month ago" and then started using a lancing device to "prick his finger." Interview with the second shift MA on 12/05/18 at 4:05pm revealed she used the same glucometer to check Resident #2's FSBS and his roommate's FSBS. Refer to interview with the first shift MA on 12/04/18 at 12:56pm. Refer to interview with the second shift MA on 12/05/18 at 4:05pm. Refer to telephone interview with the consultant pharmacist from the facility's contracted pharmacy on 12/05/18 at 2:32pm. Refer to telephone interview with the facility's contracted Nurse Practitioner (NP) on 12/05/18 at	D932		

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D932	Continued From page 16 10:35am. Refer to interview with the Administrator on 12/04/18 at 1:43pm. 2. Review of Resident #3's current FL2 dated 09/28/18 revealed diagnosis included altered mental status. Review of Resident #3's record revealed a physician's order dated 09/17/18 to check blood sugar twice daily at 8:00am and 8:00pm. Review of Resident #3's November 2018 medication administration record (MAR) revealed there was a hand written entry to check finger stick blood sugar (FSBS) twice daily scheduled for 8:00am and 8:00pm from 11/01/18 to 11/30/18. Review of Resident #3's Brand A glucometer's history revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #3's November 2018 MAR. Example of inconsistencies were as follows: -The date was set correctly but the time was an hour ahead. -The current date and time did not display when the glucometer was powered on. -On 11/26/18, at 8:07am, a FSBS reading of 94 matched the November 2018 MAR on 11/26/18 at 8:00am. -On 11/26/18, at 7:12pm, a FSBS reading of 96 matched the November 2018 MAR on 11/26/18 at 8:00pm. -On 11/26/18, there were seven additional FSBS readings in the glucometer's history that were not documented on the MAR on 11/26/18 including a FSBS reading of 122 at 8:06am, 96 at 8:09am,	D932		

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D932	Continued From page 17 101 at 8:10am, 126 at 8:11am, 121 at 8:12am, 107 at 8:13am, and 315 at 7:12pm. Review of Resident #3's December 2018 MAR revealed there was a hand written entry to check FSBS twice daily scheduled for 8:00am and 8:00pm from 12/01/18 to 12/05/18. Review of Resident #3's Brand A glucometer's history revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #3's December 2018 MAR. Example of inconsistencies were as follows: -The date was set correctly but the time was an hour ahead. -The current date and time did not display when the glucometer was powered on. -On 12/03/18, at 8:25am, a FSBS reading of 86 matched the December 2018 MAR on 12/03/18 at 8:00am. -On 12/03/18, at 8:41pm, a FSBS reading of 119 matched the December 2018 MAR on 12/03/18 at 8:00pm. -On 12/03/18, there were eight additional FSBS readings in the glucometer's history that were not documented on the MAR on 12/03/18 including a FSBS reading of 252 at 8:40pm, 149 at 2:55pm, 124 at 10:07am, 103 at 8:24am, 83 at 8:23am, 89 at 8:22am, 110 at 8:21am and 81 at 8:21am. Interview with the first shift medication aide (MA) on 12/04/18 at 12:56pm revealed: -She used the same glucometer to check Resident #3's FSBS and her roommate's FSBS. -She thought it was okay to use the same glucometer since Resident #3 was related to her roommate. -She used the lancing device on the medication cart to check Resident #3's blood sugar.	D932		

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D932	Continued From page 18 Interview with Resident #3 on 12/04/18 at 2:58pm revealed: -The MAs checked her blood sugar twice daily before breakfast and dinner. -Her blood sugar was checked in her room or in the dining room during a meal. -The MAs started using a lancing device about a month ago on her and her roommate. -The same lancing device was used on both residents. -She did not know if the MA had changed the needle between each resident. -She had noticed that the MAs would use the same glucometer to check her FSBS and her roommate's FSBS. -She had noticed that "sometimes in the dining room a different meter was used" for each resident. Interview with the second shift MA on 12/05/18 at 4:05pm revealed she used the same glucometer to check Resident #3's FSBS and her roommate's FSBS. Refer to interview with the first shift MA on 12/04/18 at 12:56pm. Refer to interview with the second shift MA on 12/05/18 at 4:05pm. Refer to telephone interview with the consultant pharmacist from the facility's contracted pharmacy on 12/05/18 at 2:32pm. Refer to telephone interview with the facility's contracted Nurse Practitioner (NP) on 12/05/18 at 10:35am. Refer to interview with the Administrator on	D932		

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D932	Continued From page 19 12/04/18 at 1:43pm. 3. Review of Resident #4's current FL2 dated 06/14/18 revealed: -Diagnoses included diabetes mellitus, chronic atrial fibrillation, hypertension, depressive disorder, iron deficient anemia, GERD, congestive heart failure, epilepsy, chronic obstructive pulmonary disease and anxiety. -There was an order to perform fingerstick blood sugar (FSBS) checks on Mondays. Review of Resident #4's November 2018 medication administration record (MAR) revealed there was an entry to check FSBS once weekly on Mondays at 7am. Review of Resident #4's Brand A glucometer's history revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #2's November 2018 MAR. Example of inconsistencies were as follows: -There were four FSBS readings that were documented on the MAR from 11/05/18 to 11/26/18, that were not in Resident #4's glucometer history, including 135 at 7am on 11/05/18, 274 at 7am on 11/12/18, 90 at 7am on 11/19, and 121 at 7am on 11/26/18. Review of Resident #4's December 2018 MAR revealed there was an entry to check FSBS once weekly on Mondays at 7am. Review of Resident #4's Brand A glucometer's history revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #2's December 2018 MAR. Example of inconsistencies were as follows:	D932		

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D932	Continued From page 20 -There was one FSBS reading that was documented on the MAR on 12/03/18, that was not in Resident #4's glucometer history of 124 at 7am. Interview on 12/05/18 at 3:00pm with Resident #4 revealed: -Her blood sugar was checked one time per week. -The medication aide (MA) checked her FSBS in the living room of the facility. -The MA always used the same type of glucometer, but she was unsure if it was labeled with her name. -She did not know if they used a lancing device or safety lancet. Refer to interview with the first shift MA on 12/04/18 at 12:56pm. Refer to interview with the second shift MA on 12/05/18 at 4:05pm. Refer to telephone interview with the consultant pharmacist from the facility's contracted pharmacy on 12/05/18 at 2:32pm. Refer to telephone interview with the facility's contracted Nurse Practitioner (NP) on 12/05/18 at 10:35am. Refer to interview with the Administrator on 12/04/18 at 1:43pm. _____ Interview with the first shift MA on 12/04/18 at 12:56pm revealed: -The facility had 7 residents with a physician's order to check FSBS. -Only 2 of the residents required FSBS checks on	D932		

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a daily basis.
-The other residents only had their FSBS checked once weekly on Monday.
-She did not know how to use all of the resident's glucometers.
-She used the same glucometer to check both residents with daily FSBS.
-She usually did not work on Monday when all the other residents had their FSBS checked.
-She had used the "back up meter" to check FSBS in the facility.
-She knew that she was not supposed to use the same glucometer on multiple residents.
-The facility was out of safety lancets.

Interview with the second shift MA on 12/05/18 at 4:05pm revealed:
-She had used the same glucometer to check all the residents FSBS on 12/03/18 because the facility was out of test strips for several of the resident's glucometers.
-She cleaned the glucometer after each resident with alcohol swabs.
-This was the first time she had used the same glucometer to check multiple residents' FSBS.
-She had sent an order to the facility's contracted Nurse Practitioner (NP) on 12/03/18 to get new prescriptions to reorder test strips for all the resident's glucometers.
-The facility was out of safety lancets on 12/03/18 and she had ordered the lancets from the pharmacy.

Telephone interview with the consultant pharmacist from the facility's contracted pharmacy on 12/05/18 at 2:32pm revealed:
-She taught the 10 hour MA training for the facility in April 2018.
-She covered basic infection control guidelines including training on the transmission of

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D932	Continued From page 22 bloodborne pathogens. -She discussed the importance of not sharing glucometers between residents and each glucometer should be cleaned based on the manufacturer's guidelines. Telephone interview with the facility's contracted NP on 12/05/18 at 10:35am revealed: -The facility should be using one glucometer per resident. -Sharing glucometers would increase the risk of spreading infections. -"The associated risk of sharing glucometers would be mild to moderate." -He had sent over new prescriptions for each resident to get a new glucometer on 12/05/18. Interview with the Administrator on 12/04/18 at 1:43pm revealed: -She was a registered nurse. -The MAs were responsible for checking the residents' FSBS. -Each resident should have their own glucometer. -She did not know that the MAs were sharing glucometers between the residents. -The facility did not have a written infection control policy. The facility failed to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines placing residents receiving finger stick blood sugar checks with glucometers at risk due to possible exposure of bloodborne pathogens by sharing of glucometers for Residents #2, #3 and #4. This failure was detrimental to the health and welfare of the resident and constitutes a Type B Violation.	D932		

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D932	Continued From page 23 The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/05/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 19, 2019.	D932		