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BURKE LONG TERM CARE	125 CAMELLIA GARDEN STREET MORGANTON, NC 28655

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D 000	Initial Comments The Adult Care Licensure Section and the Burke County Department of Social Services conducted a follow-up survey on March 28, 2019.	D 000		
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 adult care home infection prevention requirements. The findings are: 1. 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 (#1, #2, and #4) with orders for finger stick blood sugar (FSBS) monitoring resulting in the shared use of glucometers. [Refer to Tag 932 GS 131D-4.4A(b)	D912		

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D912	Continued From page 1 Adult Care Home Infection Prevention Requirements, (Type Unabated 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. (2) Require and monitor compliance with the	D932		

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D932	Continued From page 2 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: FOLLOW UP TO TYPE B VIOLATION Based on these findings the previous Type B Violation was not abated. 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 (#1,#2, and #4) with orders for finger stick blood sugar (FSBS) monitoring resulting in the shared use of glucometers. The findings are: Observation of the medication cart on 03/28/19 at 8:48am revealed: -There was 3 glucometers stored on the medication cart.	D932		

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-The glucometer's black pouches were labeled with the resident's names.
-The (Brand A) glucometers were labeled with the resident's name.

Observation of the medication room on 03/28/19 at 8:48am revealed:
-There was 5 glucometers stored on a cabinet in the medication room.
-Each glucometer and the pouches were labeled with the resident's name.
-There were disposal single use lancets for use for all the residents receiving FSBS.

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 should be used by one person only and should not be shared.

1. Review of Resident #1's current FL2 dated 01/24/19 revealed diagnoses included type 2 diabetes mellitus, hypertension, major neurocognitive disorder/dementia, and hydrocephalus with shunt.

Review of Resident #1's record revealed a physician's order dated 02/28/19 to check blood

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D932	Continued From page 4 sugar before meals scheduled for 8:00am, 12:00pm and 8:00pm. Review of Resident #1's March 2019 medication administration record (MAR) revealed there was an entry to check FSBS before meals scheduled for 8:00am, 12:00pm, and 8:00pm. Review of Resident #1's Brand A glucometer's history revealed FSBS values recorded in the glucometer's history were inconsistent compared to values documented on Resident #1's March 2019 MAR. Example of inconsistencies were as follows: -The date and time were current and set correctly. -The glucometer and the package were both labeled with Resident #1's name. -There were 4 FSBS readings that were documented on the MAR that were not in Resident #1's glucometer history on 03/19/19 of 121 at 8:00am, 03/19/19 of 74 at 12:00pm, 03/23/19 of 138 at 8:00pm, 03/24/19 of 115 at 8:00am, and on 03/25/19 of 104 at 12:00pm. -There were 6 FSBS readings in the glucometer's history that did not match the documented FSBS for Resident #1's on the MAR on 03/18/19 of 166 at 7:18pm, 03/18/19 of 164 at 7:19pm, 03/18/19 of 158 at 7:31pm, 03/23/19 of 149 at 7:19pm, 03/24/19 of 157 at 7:32am, and on 03/24/19 of 215 at 7:06pm. -There were 26 FSBS in the glucometer history that matched the documented FSBS on the MAR for Resident #1. Interview with Resident #1 on 03/28/19 at 1:45pm revealed: -She had her blood sugar checked 2 times each day before meals. -She did not know which glucometer the	D932		

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D932	Continued From page 5	D932		

medication aide (MA) used to check her blood sugar.

Refer to interview with the first shift MA on 03/28/19 at 10:33am.

Refer to telephone interview with the second shift MA on 03/28/19 at 1:30pm.

Refer to telephone interview with the consultant pharmacist from the facility's contracted pharmacy on 03/28/19 at 12:42pm.

Refer to interview with the facility's contracted Nurse Practitioner (NP) on 03/28/19 at 11:30am.

Refer to interview with the Administrator on 03/28/19 at 10:20am and on 03/28/19 at 1:40pm.

2. 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 four times daily.

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, 11:00am, 4:00pm and 8:00pm.

Review of Resident #2's March 2019 MAR revealed there was an entry to check FSBS before meals and at bedtime scheduled for 7:00am, 11:00am, 4:00pm and 7:00pm.

Review of Resident #2's Brand A glucometer's history revealed FSBS values recorded in the glucometer's history were inconsistent compared

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D932	Continued From page 6	D932		

to values documented on Resident #2's March 2019 MAR. Example of inconsistencies were as follows:
-The date and time were current and set correctly.
-The glucometer and the package were both labeled with Resident #2's name.
-There were 5 FSBS reading that were documented on the MAR that were not in Resident #2's glucometer history on 03/22/19 of 69 at 7:07am, 03/23/19 of 162 at 4:02pm, 03/25/19 of 131 at 11:53am, and on 03/26/19 of 178 at 7:56pm.
-There were 8 FSBS readings in the glucometers history that did not match the documented FSBS for Resident #2's on the MAR on 03/21/19 of 136 at 8:00pm, 03/22/19 of 98 at 8:00am, 03/22/19 of 140 at 8:00pm, 03/23/19 of 185 at 7:00pm, 03/24/19 of 140 at 8:00pm, 03/25/19 of 114 at 12:00pm, 03/26/19 of 197 at 8:00pm, 03/27/19 of 136 at 8:00am, and on 03/27/19 of 136 at 8:00am.
-There were 23 FSBS in the glucometer history that matched the documented FSBS on the MAR for Resident #2.

Interview with Resident #2 on 03/28/19 at 11:10am revealed:
-He had his blood sugar checked 4 times each day before meals.
-He did not know which glucometer the medication aide (MA) used to check his blood sugar.
-He thought he had his own but could not identify his glucometer.

Refer to interview with the first shift MA on 03/28/19 at 10:33am.

Refer to telephone interview with the second shift

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D932	Continued From page 7 MA on 03/28/19 at 1:30pm. Refer to telephone interview with the consultant pharmacist from the facility's contracted pharmacy on 03/28/19 at 12:42pm. Refer to interview with the facility's contracted Nurse Practitioner (NP) on 03/28/19 at 11:30am. Refer to interview with the Administrator on 03/28/19 at 10:20am and on 03/28/19 at 1:40pm. 3. Review of Resident #4's current FL2 dated 09/28/18 revealed: -Diagnosis included diabetes and atrial fibrillation. -There was an order to check blood sugar twice daily. Review of Resident #4's March 2019 MAR revealed there was an entry to check finger stick blood sugar (FSBS) twice daily scheduled for 8:00am and 8:00pm. Review of Resident #4's facility FSBS log revealed there were missing pages for March 2019 which identified several days in March 2019 of FSBS readings. 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 #4's March 2019 MAR. Example of inconsistencies were as follows: -The date and time were current and set correctly. -The glucometer and the package were both labeled with Resident #4's name. -There were 6 FSBS readings that were documented on the MAR that were not in	D932		

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Resident #4's glucometer history on 03/15/19 of 116 at 8:00pm, 03/16/19 of 112 at 8:00pm, 03/17/19 of 120 at 8:00pm, 03/18/19 of 122 at 8:00pm, 03/23/19 of 108 at 8:00pm, and on 03/24/19 of 122 at 8:00pm.
-There were 6 FSBS in the glucometer history that matched the documented FSBS on the MAR for Resident #4.
-On 03/21/19 at 6:21pm the FSBS recorded in Resident #4's glucometer history of 136 matched the FSBS recorded on the MAR of 136 for Resident #2's on 03/21/19 at 7:00pm.
-There were 12 FSBS readings in the glucometers history that could not be determined if they matched the FSBS for Resident #4's because the FSBS were not documented on the MAR or on the FSBS log.

Interview with the first shift medication aide (MA) on 03/28/19 at 10:30am revealed:
-The facility kept a FSBS log of all the results of the FSBS for each residents, this was kept with the MAR.
-The MAs were to document on the FSBS log and on the resident's MAR, but some of the FSBS results were not documented on the MAR's.
-The physician used the FSBS log to review the FSBS for each resident in the facility, because all the FSBS results were not documented on the MAR's.
-Resident #4 had been transported to the local hospital on 03/27/19 for a diagnoses of a urinary infection.
-The MA sent the FSBS log with Resident #4 to the hospital, but the FSBS log were not returned when Resident #4 came back to the facility on 03/27/19.
-She had sent the original facility FSBS log for Resident #4, and had not made a copy.
-She contacted the hospital on 03/28/19 and was

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D932	Continued From page 9 told by the hospital staff they had filed the FSBS log in medical records. Interview with the facility's contracted NP on 03/28/19 at 11:30am revealed: -He was seeing Resident #4 today but could not determine the FSBS, due to not having the FSBS readings on the MAR or the FSBS log. -He was not sure if he should increase Resident #4's insulin or not, due to the in-accuracy of the FSBS. -The previous week's history for Resident #4's FSBS were not available for the NP to review on 03/28/19. Interview with Resident #4 on 03/28/19 at 1:20pm revealed: -The MAs checked her blood sugar twice daily before breakfast and dinner. -Her blood sugar was usually high at times. -The MAs used a glucometer to check her FSBS that had her name on the "pouch". Refer to interview with the first shift MA on 03/28/19 at 10:33am. Refer to telephone interview with the second shift MA on 03/28/19 at 1:30pm. Refer to telephone interview with the consultant pharmacist from the facility's contracted pharmacy on 03/28/19 at 12:42pm. Refer to interview with the facility's contracted Nurse Practitioner (NP) on 03/28/19 at 11:30am. Refer to interview with the Administrator on 03/28/19 at 10:20am and on 03/28/19 at 1:40pm. _____	D932		

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D932	Continued From page 10 Interview with the first shift MA on 03/28/19 at 10:33am revealed: -There were 8 residents in the facility with a physician's order to check FSBS. -Only 3 of the residents required FSBS checks on a daily basis. -The other residents only had their FSBS checked once weekly on Monday. -She was responsible for reviewing the residents' glucometers and comparing the FSBS history. -She was responsible for documenting the results. -She did not know how to use the resident's glucometers to check the history and compare the FSBS findings to the MAR. -She had not reviewed the FSBS findings or the glucometers history. -She knew that she was not supposed to use the same glucometer on multiple residents. -She had attended an in-service the pharmacist had conducted for the MAs in December 2018, related to infection control and sharing glucometers. -The Administrator had several meetings to discuss infection prevention and each resident had their own glucometer and the glucometers were to be used only for the specific resident it was labeled for. Telephone interview with the second shift MA on 03/28/19 at 1:30pm revealed: -She had used the same glucometer to check the resident's FSBS because "sometimes she got confused". -She had documented the FSBS wrong on the MAR and the FSBS log at times. -She had not attended the in-services for diabetic training conducted by the pharmacist. Telephone interview with the consultant	D932		

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pharmacist from the facility's contracted pharmacy on 03/28/19 at 12:42pm revealed:
-She taught the MAs training for the facility on 12/31/18, and she thought about 5-6 MAs had attended.
-The training was mandatory for all the MAs.
-She covered infection control guidelines including training on the transmission of bloodborne pathogens.
-She discussed the importance of not sharing glucometers between residents and each glucometer should be cleaned based on the manufacturer's guidelines.
-She discussed the use of single dose lancets to be used for all the residents in the facility.

Interview with the facility's contracted NP on 03/28/19 at 11:30am revealed:
-He did not know the facility staff were sharing glucometers.
-The facility should be using one glucometer per resident, that's was why each resident had their own glucometer.
-"How can I dose the insulin if I am not sure if the FSBS readings are accurate."
-He would write a new prescriptions for each resident to get a new glucometer on 03/28/19.

Interview with the Administrator on 03/28/19 at 10:25am revealed:
-The MAs were responsible for checking the residents' FSBS.
-Each resident should have their own glucometer.
-She had ordered new glucometers for each resident in December 2018.
-She had several meetings with the staff to discuss infection prevention and not sharing glucometers between residents.
-She had contacted the pharmacist for additional training for all MAs.

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D932	Continued From page 12 -The pharmacist held the training on 12/31/18 and it was mandatory for all MAs. -She did not know that the MAs were sharing glucometers between the residents. -She had not checked behind the MAs to ensure they were no sharing glucometers. -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 #1, #2 and #4. This failure was detrimental to the 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 03/28/19 for this violation.	D932		