STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096028	A. BUILDING _____ B. WING _____	11/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARE OF MT OLIVE	600 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(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 Surveyor: NC168 The Adult Care Licensure Section conducted a complaint investigation survey at the facility on October 15, 2010 and October 18-20, 2010. The complaint investigation was extended and the exit conference was conducted via telephone on November 05, 2010.	D 000		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Surveyor: 96553	D 164		

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D 164	Continued From page 1 THIS IS A TYPE B VIOLATION WITH A DIRECTED DATE OF CORRECTION Based on record review and interview, the facility failed to assure 3 of 3 sampled Medication Aides (Staff A, B, C) received training on the care of residents with diabetes, including blood glucose monitoring and universal precautions, prior to the administration of Insulin. The findings are: 1. Record review of information provided by the facility revealed Staff A was hired on 10/13/04. Further review revealed no documentation that Staff A had received training on universal precautions as related to blood glucose monitoring. Review of additional information provided by the facility revealed Staff A worked as a Medication Aide (MA). Staff A was not available for interview. Review of the October 2010 Medication Administration Records revealed documentation that Staff A had administered Insulin. Refer to interview with the Operations Manager dated 10/20/10 at 8:59am and record review. Refer to interview with RN Consultant dated 10/20/10 at 9:10am. 2. Record review of information provided by the facility revealed Staff B was hired on 5/3/10 as a Medication Aide (MA). Further review revealed no documentation that Staff B had received training on universal precautions as related to blood glucose monitoring. Staff B was not available for interview. Review of the September and October 2010 Medication Administration Records revealed	D 164		

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D 164	Continued From page 2 documentation that Staff B had administered Insulin. Refer to interview with the Operations Manager dated 10/20/10 at 8:59am and record review. Refer to interview with RN Consultant dated 10/20/10 at 9:10am. 3. Record review of information provided by the facility revealed Staff C was hired on 9/22/10. Further review revealed no documentation that Staff C had received training on universal precautions as related to blood glucose monitoring. Review of additional information provided by the facility revealed Staff C worked as a Medication Aide (MA). Staff C was not available for interview. Review of the October 2010 Medication Administration Records revealed documentation that Staff C had administered Insulin. Refer to interview with the Operations Manager dated 10/20/10 at 8:59am and record review. Refer to interview with RN Consultant dated 10/20/10 at 9:10am. _____ During interview on 10/20/10 at 8:59am, the Operations Manager presented 3 documents to verify Diabetic training; one dated 3/1/10, another dated 9/27/10 and the third one dated 10/16/10. Review of the first document, dated 3/1/10, was titled "Inservice Education" and included the sub heading, "Appendix B Inservice Education Program Summary". The Program Title was	D 164		

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D 164	Continued From page 3 documented as "Diabetes & Insulin Administration". Documented under the area "Program Content" were staff names in attendance and did not include the names of Staff A, Staff B or Staff C. Attached to the form were 3 sheets of paper and none of the three included content regarding using universal precautions when performing blood glucose monitoring or any other infection control measures when handling blood or body fluids. Review of the second document, a single-paged document dated 9/27/10, was titled "Inservice Education" and included the sub heading, "Appendix A Inservice Education Attendance Record". The Program Title was documented as "Diabetes & Insulin Administration". Further review revealed Staff A and Staff B names were documented on the form. Staff C's name was not on the form. Continued interview with the Operations Manager at 9:06am revealed, "The content was the same for both in-services" [3/1/10 and 9/27/10]. Interview on 10/20/10 at 9:10am with the RN Consultant whose name was documented as the instructor for the 9/27/10 training revealed, "That is not the content I used for the training I did". The nurse later presented a 3-inch, 3-ring binder and stated the contents within the binder was the course content she used for the training on 9/27/10. The nurse further stated that she condensed the information into one-hour training. There was no information regarding universal precautions. On Friday, 10/22/10, additional information was received from the facility at a Division of Health Service Regulation regional office. This	D 164		

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D 164	Continued From page 4 information included content used by the contract pharmacy nurse for training on "Diabetes and Insulin Administration." Review of the information revealed no training content regarding the use of Universal Precautions when performing blood glucose monitoring on residents or any other infection control measures when handling blood or body fluids. On 11/1/10, a fax was received at a DHSR regional office from the facility's RN Consultant. The fax cover sheet documented, "I found my in-service stuff in my nurse consultant book in my trunk..." Review of the information revealed the last slide was titled, "Universal Precautions". THE DATE OF CORRECTION SHALL NOT EXCEED NOVEMBER 19, 2010.	D 164		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Surveyor: NC168 Based on observation, interview, and record review, the facility failed to assure that Residents' Rights as guaranteed under G. S. 131D-21 were maintained for all residents and exercised without hindrance. The findings are: 1. Based on interview, the facility failed to assure that residents were treated with respect and dignity. [Refer to Tag 911 G. S. 131D-21(1)	D 338		

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	HAL096028	A. BUILDING _____ B. WING _____	11/05/2010

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D 338	Continued From page 5 Residents' Rights (Type B Violation)]. 2. Based on observations, interviews, and record review, the facility failed to assure 6 of 6 (including four recent resident deaths) sampled diabetic residents (Residents #1, #2, #3, #4, #5, and #6) requiring fingerstick blood sugar testing received appropriate care and services in accordance with infection control measures. [Refer to Tag 912 G. S. 131D-21(2) Residents' Rights (Type A Violation)]. Surveyor: NC319	D 338		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Surveyor: 96553 THIS IS A TYPE B VIOLATION WITH A DIRECTED DATE OF CORRECTION. Based on interviews, the facility failed to assure that all residents were treated with respect and dignity as evidenced by confidential interviews with staff and residents. The findings are: Confidential interviews with 5 of 5 staff and 3 of 7 residents revealed Staff E failed to treat residents with respect, consideration and dignity:	D911		

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	HAL096028	A. BUILDING _____ B. WING _____	11/05/2010

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D911	Continued From page 6 A. Interviews revealed Staff E "has an anger problem", takes it out on staff and residents and it is getting worse. B. Interviews revealed Staff E has been heard to talk "nasty" to other residents and staff and interview with a resident revealed a resident was concerned about staff working under those conditions because it could affect "the way they [staff] treat us". Interview revealed Staff E is "nasty" to 2 of the female residents and one of the residents has been observed coming out of Staff E's office crying on several occasions. C. Interviews revealed that Staff E talks to the residents just as cruel as he does the employees. On several occasions Staff E has gone into a female resident's room alone and cursed her out so loudly that family members, staff and other residents could hear it down the hall, "well and clear". The interview went on to report that Staff E has been reported to several agencies but when the allegations were being investigated, "the owners covered for him". D. Continued interview revealed about three months ago, the transportation staff was told to come back after hours to transport 3 residents to a church downtown to attend an Alcoholics Anonymous (AA) meeting in the facility vehicle. Further interview revealed the female resident had to use another resident's electric wheelchair because the resident's electric wheelchair was not working properly. Continued interviews revealed two residents were transported in the evening to a meeting at a church downtown. Further interviews revealed a third resident did not ride in the facility vehicle	D911		

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D911	Continued From page 7 because the transportation vehicle (a van) was too high for the resident to transfer into. The resident had to ride in a motorized wheelchair. The driver of the transportation vehicle drove alongside the resident to the church. When the staff and residents arrived at the church, two of the three residents were able to walk into the church. The resident who had ridden the motorized wheel chair to the meeting was not able to attend the meeting because the church was not equipped with handicap access. According to interview, the resident in the motorized wheelchair and the transportation staff had to sit out in the parking lot for approximately 15 minutes, while the other residents attended the meeting. Confidential interview revealed the resident and the transporter were sweating heavily because it was hot outside. When the meeting was over, the resident had to return to the facility riding the motorized wheelchair in the hot weather. Further interviews revealed the resident had a choice to ride the wheelchair or ride a commercial transportation vehicle. The interview further revealed that if the resident had chosen the commercial transportation, the resident would have had to pay for the transportation. Interview with a representative of the commercial transportation company mentioned by staff above on 10/26/10 at 3:20pm revealed that no insurance will cover the transport of people in wheelchairs. Further interview revealed there is no contract between the facility and the commercial transportation company, and the resident would be responsible for paying for the transport. E. Interview revealed three residents were reported to Staff E regarding alcohol consumption	D911		

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D911	Continued From page 8 on the facility's premises. The interview revealed a resident had not been drinking but was told by Staff E that the resident would have to attend an AA meeting. The interview revealed the resident did not want to go to the AA meeting because the resident had not been drinking alcohol but stated the three residents were made to go. At the conclusion of the confidential staff and resident interviews, Staff E was not interviewed regarding the above statements. Staff E had left the facility in the early morning on 10/20/2010. On 10/20/10 at 11:05am during a conference requested by the facility, the Vice President of the corporation revealed that Staff E was in training. The Vice President stated she was aware of how Staff E treats staff and residents; and, there had been a previous concern. The Vice President also stated, "We discussed some anger management classes and senstivty training. I want to pull him out of this environment and get him some help". THE DATE OF CORRECTION SHALL NOT EXCEED NOVEMBER 19, 2010.	D911		
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: Surveyor: NC168 THIS IS A TYPE A VIOLATION WITH A DIRECTED PLAN OF CORRECTION.	D912		

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D912	Continued From page 9 1. Based on observations, interviews, and record review, the facility failed to assure 6 of 6 sampled diabetic residents (Residents #1, #2, #3, #4, #5, and #6) requiring fingerstick blood sugar testing (including four recent resident deaths) received appropriate care and services in accordance with infection control measures. The findings are: On 10/12/10 the Division of Public Health was notified by the local County Health Department of 2 confirmed cases of Hepatitis B in residents admitted to the local hospital from the facility. A total of four residents had been admitted to the hospital from the facility and all were diabetics. One of the residents, who had been admitted to the hospital around the end of August 2010, died around the first of September 2010 (Resident #1). On 10/13/10, a representative from the Division of Public Health made an onsite visit to look into reported cases of acute Hepatitis B infections of residents of the facility, and the possible modes of transmission. (According to guidelines by The Center for Disease Control, Hepatitis B is transmitted by exposure to infectious blood and body fluids.) On 10/15/10, an onsite visit was conducted by Division of Public Health and Division of Health Service Regulation. During this visit, it was revealed that the Division of Public Health had "identified 6 confirmed or suspected cases among residents of facility within the past three months, including three deaths" (Resident #1, #2, #4). While onsite on 10/15/10 it was revealed that a fourth resident had died (Resident #3). Record reviews revealed documentation that all	D912		

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D912	Continued From page 10 six residents had been tested by fingersticks for blood glucose monitoring by facility staff. Review of the information provided by the facility and residents' records revealed: a. Resident #1 had been tested twice a day; b. Resident #2 had been tested twice a day; c. Resident #3 had been tested twice a day; d. Resident #4 had been tested four times a day; e. Resident #5 was being tested twice a day; and f. Resident #6 was being tested four times a day. Observation of a Medication Aide (MA) on 10/15/10 at 3:45pm preparing to perform fingerstick blood sugar (FSBS) testing on residents revealed the MA removed the fingerstick testing supplies from the top drawer of the medication cart. The fingerstick testing supplies included a test strip (used to receive the blood sample for measuring the blood glucose level), a glucometer labeled with the resident's name (a glucometer is a machine that reads the blood sample applied to the test strip), a lancet (used for pricking the finger to obtain the blood sample), an alcohol wipe, and an unlabeled lancing pen device (a spring-loaded device that quickly pierces the skin). Observation of the medication cart top drawer contents at this time revealed two unlabeled lancing device pens and four uncovered resident labeled glucometers. The uncovered glucometers were positioned next to each other in a small plastic bin inside the medication cart drawer. On top of the medication cart was a spray bottle of clear liquid labeled bleach and water. Further observation of the Medication Aide (MA) on 10/15/10 revealed the MA placed the lancet in the lancing device pen, cleaned the resident's 4th finger with an alcohol swab, and pricked the	D912		

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D912	Continued From page 11 resident's finger with the lancing device pen to obtain the blood sample for FSBS testing. Continued observation of the Medication Aide on 10/15/10 revealed following the FSBS testing, the MA placed the used test strip in the trash can, placed the lancet in the sharps container attached to the medication cart, removed gloves, unlocked the medication cart and returned the glucometer and lancing device pen to the medication cart drawer, documented the FSBS, and washed her hands in the hallway bathroom. The MA was not observed to clean the lancing device pen or the glucometer prior to use or after use. Record review of the facility policy and procedure for Capillary Blood Sampling revealed the purpose of the policy was to provide guidelines for the safe handling of capillary blood sampling devices to prevent transmission of bloodborne diseases to residents and employees. The procedure included "wipe any visible blood from the spring-loaded device with alcohol pledgets, multi-use spring loaded capillary-blood sampling devices have been implicated in the transmission of Hepatitis B, sampling devices that do not use a platform should be disinfected following manufacturer's instructions", and "the patient will be individualized, and will have their own lancet device, and own glucometer, assigned to them. This will eliminate the risk of cross-contamination." Confidential staff interviews revealed the following regarding blood glucose monitoring: a. Confidential staff interview revealed only one lancing device was available in the medication cart up until last week (the week of	D912		

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D912	Continued From page 12 October 11, 2010). The interview revealed staff reported concerns to the supervisor about having only one lancing pen device between multiple diabetic residents, and was told,"they did not have individual supplies and it had always been this way". The interview revealed the diabetic residents at the facility did not have their own lancing device and the one device in the medication cart was being shared between all the diabetic residents. The interview revealed the staff member cleaned the lancing device before and after it was used but was unable to state if this practice was performed by all staff at the facility. The interview revealed staff was aware of an incident in which a lancet was left in the lancing device and another staff member was almost stuck with the same lancet. b. Another confidential staff interview revealed the staff cleaned and disinfected the glucometers and lancing device pens with an alcohol swab when the devices looked like there was something on the device. The staff was not aware of a protocol for disinfecting the glucometer and lancing device pens. Interviews revealed each resident had not always had their own glucometer. The staff did not know how long the glucometers labeled with residents' names had been in the facility. Further interview revealed the individual glucometers and lancing device pens had probably come to the facility on 10/11/10 and there were no individually labeled glucometers or lancing device pens before. Interviews revealed there were usually one or two unlabeled glucometers and lancing device pens on the medication carts which were used on all residents for blood glucose monitoring. c. A third confidential staff interview revealed the staff thought she had seen the individual lancing	D912		

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D912	Continued From page 13 device pens and glucometers on the medication carts. Further interview revealed a shipment of supplies for blood glucose monitoring came to the facility two weeks ago. Interview revealed individual glucometers and lancing device pens had been on the medication carts for about two weeks. Interviews revealed the bleach and water solution for cleaning the glucometers and lancing device pens had been added as recent as 10/14/10. Interviews revealed there was usually hand antiseptic cleaner on the medication carts for the medication aides to sanitize their hands. d. A fourth confidential staff interview revealed the facility did not have individual lancing device pens for each resident until the morning of 10/14/10, when the facility received a box of lancing device pens and labeled them with the residents' names. The staff reported before 10/14/10, the staff would prick one resident's finger, remove the lancet and place another lancet in the lancing device pen without cleaning the lancet device pen. e. A fifth confidential staff interview revealed the facility had only one lancing device pen on each medication cart to use for everybody. The staff reported that staff usually wiped off the top of lancing device pen after taking the lancet out but reported using the same lancing device pen for blood glucose monitoring on each resident. Record review for 3 of 3 sampled Medication Aides (Staff A, B, C) revealed these staff had not received training on the care of residents with diabetes, including blood glucose monitoring and universal precautions, prior to the administration of insulin. (Refer to Tag D164, 10A NCAC 13F.0505 Training on Care of Diabetic Residents)	D912		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN CARE OF MT OLIVE	600 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(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
D912	Continued From page 14 Confidential interviews with 4 of 4 residents during the survey revealed there were concerns which included the following: a. Confidential resident interview revealed staff "lately" did not act like they knew what they were doing. Staff would touch the resident's finger 3-4 times thinking they have pricked it, go out of room and confer with someone, come back and prick the resident's finger. The resident stated there had been an "outbreak, can't think of the word, had some deaths here, something B, Type B, don't know the word, people 3, 4,or 5 died". b. Another confidential resident interview revealed, "All staff have used the same machine to check blood sugars "and "just recently everybody got their own." This resident stated, "just recently" meant "few months ago." c. A third confidential resident interview revealed staff come into this resident's room with their needle and alcohol. The resident stated staff come to the resident's room, wipe the resident's finger with alcohol, and stick the resident's finger. This resident stated the resident did not have a glucometer and did not see the glucometer used by staff. d. A fourth confidential resident interview revealed the resident required blood glucose monitoring. The resident stated "I do not have my own machine." The interview revealed staff at the facility always performed the finger stick blood sugar testing in the resident's room. Interview with the Registered Nurse (RN) Consultant on 10/19/10 at 8:55am revealed the facility infection control measures used by the	D912		

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D912	Continued From page 15 facility were according to universal precautions prior to the Hepatitis B outbreak. The RN Consultant stated a new policy and procedure was added afterwards for staff monitoring of residents. The RN Consultant stated any findings of signs and symptoms listed were to be reported to the Resident Care Coordinator, who would report the findings to the Operations Manager, who would contact the RN Consultant and the RN Consultant would make an assessment. The RN Consultant stated the medication aides were inserviced on 10/15/10, 10/16/10 and 10/17/10 about the new policy and procedure, and the new resident monitoring form. Interview with one of the facility's owners on 10/20/10 at 11:05am revealed the facility makes every effort not to transmit disease and thinks they know where the disease came from. The representative stated the facility was doing an investigation. Interviews with Public Health Department Representatives on 10/25/10 and 10/28/10 revealed an ongoing investigation in the facility because of a recent outbreak of acute Hepatitis B infections. The representative reported recent deaths in the facility of residents who tested positive for Hepatitis B infection. The interviews revealed blood glucose testing was a "commonality" in facility residents testing positive for the Hepatitis B infection. The representatives stated there were concerns of the facility not cleaning and disinfecting blood glucose monitoring glucometers and lancing pen devices between resident use, storage of glucometers, and loose blood glucose monitoring devices not labeled for residents. The representatives stated their investigation was not concluded but was "plausible" association that the acute Hepatitis B	D912		

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D912	Continued From page 16 infection transmission could be associated with glucose monitoring devices. The representative stated the facility has been cooperative with the Public Health Department recommendations. Observations on 10/18/10 and 10/20/10 revealed facility staff were following the recommended infection control measures regarding blood glucose monitoring. Directed Plan of Correction A. The facility is to assure all residents are provided adequate and appropriate care regarding infection control measures, including blood glucose monitoring. Notification or contact with physicians or other health care providers concerning the residents is to be documented in the residents' records. TO BEGIN IMMEDIATELY. B. The facility is to develop and implement policies and procedures for infection control measures IMMEDIATELY that prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment. The policies and procedures will include proper handwashing technique, use of separate glucometers and lancing devices for individual residents, equipment sanitation and disinfecting techniques, and other work practice controls to prevent exposure to blood borne pathogens. A registered nurse or prescribing practitioner is to be involved in the development of the policies and procedures. C. The facility will designate one staff member to coordinate all infection control activities. These activities include ensuring that all staff members	D912		

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D912	Continued From page 17 are trained in the principles of infection control and the practices required by the facility's infection control policy; requiring and monitoring compliance with the policy; and updating the policy as needed to prevent disease transmission. This designated staff member must complete a course in infection control approved by the North Carolina Department of Health and Human Services, in accordance with NC Administrative Code rule 10A NCAC 41A .0206. D. An in-service for current staff for these policies and procedures is to be held IMMEDIATELY. There is to be documentation of the in-service, which shall include content of topics discussed, the date of the in-service, and a list of those in attendance. Subsequent inservices of policies and procedures will occur for new staff prior to new staff being given work assignments. E. Observation of blood glucose monitoring is to be done at least once weekly by a registered nurse or registered pharmacist. Different shifts and staff are to be observed. This process is to include documentation of observation of medication aides procedure for blood glucose monitoring. These results of each observed blood glucose monitoring are to be documented and available for review. This process is TO BEGIN IMMEDIATELY and continue until compliance is determined by Adult Care. F. The facility is to identify a quality assurance program or system for monitoring compliance in the areas identified above. The facility is to maintain documentation of the monitoring and frequency of monitoring of these areas.	D912		

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D912	Continued From page 18 THE DATE OF CORRECTION FOR THE TYPE A VIOLATION SHALL NOT EXCEED NOVEMBER 19, 2010. 2. Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to staff training on care of diabetic residents. The findings are: Based on record review and interview, the facility failed to assure 3 of 3 Medication Aides (Staff A, B, C) received training on the care of residents with diabetes, including blood glucose monitoring and universal precautions, prior to the administration of Insulin. [Refer to Tag 0167 10A NCAC 13F .0505 Training on Care of Diabetic Resident (Type B Violation)].	D912		