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LAURELWOODS	1062 WEST MILLS STREET COLUMBUS, NC 28722

(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 and the Polk County Department of Social Services conducted an annual and follow-up survey on 06/27/23 to 06/30/23.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or moving into an adult care home, the administrator, all other staff, and any persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. Amended Eff. July 1, 2021 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) were tested for tuberculosis (TB) disease upon hire. The findings are: Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was rehired on 05/19/22. -There was a step 1 TB skin test dated 03/26/20 with a negative result. -There was a step 2 TB skin test dated 04/02/20 with a negative result. -There was no documentation of a TB skin test after rehire on 05/19/22. Interview with the Business Office Manager on 06/28/23 at 11:21am revealed:	D 131		

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D 131	Continued From page 1 -She was responsible for maintaining staff qualification records. -There was no documentation of TB skin tests for Staff B after 05/19/22. -The Health and Wellness Director (HWD) was responsible for completing TB skin tests for Staff B upon rehire. Interview with the Resident Care Coordinator (RCC) on 06/29/23 at 9:16am revealed the HWD's position was currently vacant. Interview with the Administrator on 06/30/23 at 8:44am revealed: -It was the facility's policy to complete TB skin tests or a chest x-ray on all new employees. -The Administrator was responsible for ensuring new hires were tested appropriately for TB. -Staff B was a rehire and she did not think to do a TB skin test.	D 131		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure physician's orders were implemented for 3 of 7 sampled residents (#1, #6,	D 276		

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and #11) related to a swallow study not completed (#6) and for not notifying the primary care provider of fingerstick blood sugar readings greater than 300 (#1 and #11).

The findings are:

1. Review of Resident #6's current FL2 dated 04/24/23 revealed diagnoses included cancer of the esophagus, dementia, and Alzheimer's disease.

Review of a physician's order dated 05/02/23 revealed an order for a swallow study.

Review of Resident #6's record revealed there were no test results for a swallow study completed.

Review of Resident #6's chart notes revealed there was no documentation of swallow study results or for any notifications to the hospice provider that a swallow study was not completed.

Telephone interview with a home health agency (HHA) representative on 06/29/23 at 2:45pm where Resident #6's referral for a swallow study should have been faxed revealed:
-Resident #6 did not receive services through their agency.
-They did not receive the order dated 05/02/23 for a swallowing study for Resident #6.

Interview with the Resident Care Coordinator (RCC) on 06/29/23 at 4:00pm revealed:
-She did not know a swallow study was ordered on 05/02/23 for Resident #6.
-The medication aide (MA) supervisor that worked on 05/02/23 was responsible to fax Resident #6's order for the swallow study to the

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facility's contracted HHA for a speech therapist to perform the swallow study for Resident #6.
-The order for the swallow study was not faxed to the facility's contracted HHA because there was no "faxed" stamp on the order.
-She thought any type of evaluation test would not be covered by insurance when a resident received hospice services.
-The MA supervisor did not document in the chart notes the reason the order for the swallow study for Resident #6 was not faxed.

Interview with the hospice registered nurse (RN) on 06/30/23 at 10:12am revealed:
-She gave the MA supervisor the order for Resident #6's swallow study on 05/02/23.
-She told the MA supervisor the swallow study would not be covered by insurance since Resident #6 was a hospice patient, but hospice would pay to have the swallow study completed.
-It was important for Resident #6 to have the swallow study completed because he was getting choked on food and liquids and it was important to determine whether the cause was related to a progression of the esophageal cancer.
-She did not realize the swallow study was not completed for Resident #6.
-The facility did not notify hospice the swallow study was not completed for Resident #6 and should have followed up to clarify if the swallow study was still needed or obtain new orders.

Telephone interview with the hospice provider on 06/28/23 at 11:40am revealed:
-She received a referral request to take over Resident #6's care on 06/26/23.
-Resident #6 had been under the care of a different hospice provider for throat cancer until he was admitted to the facility on 04/27/23.
-Resident #6 was ordered to continue a pureed

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diet and change from regular liquids to nectar thickened liquids on 06/07/23 because of choking, vomiting, and dysphagia.
-The hospice RN saw Resident #6 weekly and she gave the RN a verbal telephone order on 05/02/23 for the facility to obtain a swallow study for Resident #6 due to choking and vomiting while eating and to see if Resident #6's throat cancer had progressed.
-She could not find any results that a swallow study was completed for Resident #6.
-She was not notified by the facility that the swallow study had not been done for Resident #6.
-She expected the facility to obtain the swallow study for Resident #6 because Resident #6's throat cancer may have progressed which could lead to aspiration of food or drink causing pneumonia or infection.

Interview with the Administrator on 06/30/23 at 9:35am revealed:
-She did not know there was an order for a swallow study for Resident #6 or that the order was missed.
-The order should have been faxed to the facility's contracted home health agency for a speech therapist to perform the swallow study.
-The MA supervisor should have documented in the chart notes the reason why the swallow study was not completed.
-She expected the MAs, MA supervisor, and RCC to make sure all orders were completed for residents.

Telephone interview with Resident #6's responsible person on 06/29/23 at 4:21pm revealed:
-Resident #6 had esophageal cancer and was spitting up his food.
-She last saw him get choked on food on

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06/18/23.
-The facility told her the Hospice provider ordered a swallow study, but the facility never took Resident #6 for the test and one of the MAs told her it would take the facility a while to get the test completed.
-She did not know if a swallow study was completed for Resident #6 yet.

Attempted telephone interview with the MA supervisor on 06/29/23 at 12:40pm was unsuccessful.

2. Review of Resident #1's current FL2 dated 01/25/23 revealed diagnoses included diabetes mellitus type 2.

Review of Resident #1's physician's order dated 05/19/23 revealed an order for fingerstick blood sugar (FSBS) checks three times a day before meals and notify the primary care provider (PCP) if the reading was less than 80 or greater than 300.

Review of Resident #1's chart notes revealed:
-On 05/17/23, there was documentation the facility would check FSBS 3 times a day before meals.
-There was no documentation of any notifications to the PCP in May 2023 or June 2023 for the FSBS readings greater than 300.

Review of Resident #1's May 2023 electronic medication administration record (eMAR) from 05/17/23 thorugh 05/31/23 revealed:
-There was an entry for FSBS checks three times a day at 6:00am, 11:30am, and 4:30pm and call the PCP for readings less than 80 or greater than 300.
-There was documentation of 7 instances out of

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44 opportunities where the FSBS reading was greater than 300 and the PCP was not notified of the FSBS reading.

Review of Resident #1's June 2023 eMAR from 06/01/23 through 06/27/23 revealed:
-There was an entry for FSBS checks three times a day at 6:00am, 11:30am, and 4:30pm and call the PCP for readings less than 80 or greater than 300.
-There was documentation of 2 instances out of 79 opportunities where the FSBS reading was greater than 300 and the PCP was not notified of the FSBS reading.

Interview with Resident #1 on 06/27/23 at 10:06am revealed:
-She had diabetes and was ordered a diabetic diet.
-Staff checked her FSBS three times a day.
-Sometimes her FSBS readings were high.

Interview with a medication aide (MA) on 06/28/23 at 12:40pm revealed:
-She documented a FSBS reading of 310 for Resident #1 on 06/25/23 at 11:30am.
-She notified the PCP of the FSBS reading greater than 300 but forgot to document the notification.
-She was supposed to document any notifications to the PCP in the chart notes.

Interview with the Resident Care Coordinator (RCC) on 06/28/23 at 3:03pm revealed:
-The MA should have notified the PCP of any FSBS readings greater than 300 and documented the notification on the eMAR or in the chart notes.
-The Health and Wellness Director (HWD) was responsible for eMAR audits to check for accuracy of documentation and the facility did not

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have a HWD currently.

Telephone interview with the PCP on 06/29/23 at 10:33am revealed:
-Resident #1 was sometimes non-compliant with her diet and it caused her to have high FSBS readings.
-He ordered FSBS checks three times a day before meals on 05/19/23 and for the facility staff to notify him of FSBS readings less than 80 or greater than 300.
-He did not document and could not remember when the facility notified him last that Resident #1's FSBS was greater than 300.
-He expected the facility staff to notify him when Resident #1's FSBS readings were greater than 300.

Interview with the Administrator on 06/29/23 at 11:54am revealed:
-She did not know Resident #1 had FSBS readings greater than 300 in May 2023 and June 2023 and the MAs did not notify the PCP as ordered.
-The MAs were responsible to follow orders and notify the PCP when the FSBS reading was less than 80 or greater than 300 and document the notifications in the chart notes.
-She did not know why the MAs did not notify the PCP or document the notifications in the chart notes.

3. Review of Resident #11's current FL2 dated 02/21/23 revealed diagnoses included diabetes mellitus type 2 and dementia.

Review of Resident #11's physician's order dated 05/19/23 revealed an order for fingerstick blood sugar (FSBS) checks three times a day before meals and notify the primary care provider of

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D 276	Continued From page 8 FSBS readings less than 80 or greater than 300. Review of Resident #11's chart notes revealed: -On 05/17/23, there was documentation the facility would check FSBS 3 times a day. -There was documentation on 06/29/23 at 7:18am the PCP was notified of a FSBS reading of 304. -There was no documentation of a notification to the PCP on 5/20/23 at 4:30pm of a FSBS reading of 352. Review of Resident #11's May 2023 electronic medication administration record (eMAR) from 05/17/23 through 05/31/23 revealed: -There was an entry for FSBS checks three times a day at 6:00am, 11:30am, and 4:30pm and call the PCP for readings less than 80 or greater than 300. -There was documentation of 3 instances out of 45 opportunities where the FSBS reading was greater than 300 and the PCP was not notified of the FSBS reading. Review of Resident #11's June 2023 eMAR from 06/01/23 through 06/29/23 at 6:00am revealed: -There was an entry for FSBS checks three times a day at 6:00am, 11:30am, and 4:30pm and call the PCP for readings less than 80 or greater than 300. -There was documentation of 15 instances out of 79 opportunities where the FSBS reading was greater than 300 and the PCP was not notified of the FSBS reading. Interview with a medication aide (MA) on 06/28/23 at 12:40pm revealed: -She documented a FSBS reading of 303 for Resident #11 on 06/25/23 at 4:30pm. -She notified the PCP of the FSBS reading	D 276		

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greater than 300 but forgot to document the notification.
-She was supposed to document any notifications to the PCP in the chart notes.

Interview with the Resident Care Coordinator (RCC) on 06/28/23 at 3:03pm revealed:
-The MA should have notified the PCP of any FSBS readings greater than 300 and documented the notification on the eMAR or in the chart notes.
-The Health and Wellness Director (HWD) was responsible for eMAR audits to check for accuracy of documentation and the facility did not have an HWD currently.

Telephone interview with the PCP on 06/29/23 at 10:33am revealed:
-He ordered FSBS checks for Resident #11 three times a day before meals on 05/19/23 and for the facility staff to notify him of FSBS readings less than 80 or greater than 300.
-He did not document and could not remember when the facility notified him last that Resident #11's FSBS was greater than 300.
-He received a call from the facility around 5:00am or 6:00am on 06/29/23 but could not recall who called him, which resident the facility called about, or what he was told by the facility staff.
-He did not know if the facility staff notified him of Resident #11's FSBS reading being 304 on 06/29/23 at 6:00am.
-He expected the facility staff to notify him when Resident #11's FSBS readings were greater than 300.

Interview with the Administrator on 06/29/23 at 11:54am revealed:
-She did not know Resident #11 had FSBS readings greater than 300 in May 2023 and June

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D 276	Continued From page 10 2023 and the MAs did not notify the PCP as ordered. -The MAs were responsible to follow orders and notify the PCP when the FSBS reading was less than 80 or greater than 300 and document the notifications in the chart notes. -She did not know why the MAs did not notify the PCP or document the notifications in the chart notes. _____ The facility failed to ensure a physician's order for a swallow study was completed for a resident who had esophageal cancer and experienced choking and vomiting while eating and drinking fluids which increased the risk of aspiration, infection, or pneumonia (Resident #6). This failure was detrimental to the health of Resident #6 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 06/30/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 14, 2023.	D 276		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	D 296		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for food service guidance for 2 of 5 sampled residents (#4 and #6) with physician's orders for a pureed diet and nectar thickened liquids (#6) and a heart healthy diet (#4).

The findings are:

1. Review of Resident #6's current FL2 dated 04/24/23 revealed:
-Diagnoses included cancer of the esophagus, dementia, and Alzheimer's disease.
-Regular diet was ordered.

Review of Resident #6's physician's orders revealed there was an order dated 06/07/23 to continue a pureed diet and change Resident #6's liquids to nectar thickened consistency.

Review of the therapeutic diet list updated on 06/27/23 and posted in the kitchen revealed Resident #6 was listed as a pureed diet with nectar thickened liquids.

Observation of the kitchen on 06/27/23 at 9:52am revealed there were no therapeutic diet menus available including a pureed diet.

Interview with the Dietary Manager on 06/27/23 at 11:25am revealed:
-She was hired to work for the facility for about 6 weeks.
-There was no therapeutic diet menus available for review for therapeutic diets including a pureed

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diet.
-She did not know what a therapeutic diet menu was.

Refer to the interview with the Administrator on 06/27/23 at 4:06pm.

Refer to the interview with the Dietary Manager on 06/28/23 at 11:54am

Refer to the interview with the Administrator on 06/29/23 at 11:54am.

2. Review of Resident #4's current FL2 dated 02/16/23 revealed:
-Diagnoses included dementia, congestive heart failure, atrial fibrillation, hypertension, hyperlipidemia, history of a heart attack, and diabetes mellitus type 2.
-There was an order for a heart healthy diet (according to the American Heart Association, a heart healthy diet recommended low sodium, low saturated fat, and low sugar intake).

Review of the therapeutic diet list updated on 06/27/23 and posted in the kitchen revealed Resident #4 was listed as a heart healthy diet.

Observation of the kitchen on 06/27/23 at 9:52am revealed there were no therapeutic diet menus available, including a heart healthy diet menu.

Interview with the Dietary Manager on 06/27/23 at 11:25am revealed:
-There was no diet extensions menu available for review for therapeutic diets including a heart healthy diet.
-She was instructed by the Administrator that the menu supplied by the facility's contracted menu company were all considered heart healthy.

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D 296	Continued From page 13 -She did not know what a therapeutic diet extension menu was. Observation of Resident #4's lunch meal service on 06/27/23 at 12:00pm revealed: -The dietary aide (DA) brought Resident #4's lunch tray consisting of an all-beef hotdog on a white bread bun, a serving of home style potato chips, a small bowl of blueberry cobbler, a small plastic bowl of sauerkraut, a glass of tea, and a glass of cranberry juice. -It could not be determined if Resident #4 was served the correct therapeutic diet due to a heart healthy diet menu was not available for staff guidance. Interview with Resident #4's primary care provider (PCP) on 06/29/23 at 10:33am revealed: -Resident #4 had heart disease including congestive heart failure, atrial fibrillation, hyperlipidemia, hypertension, and a history of a heart attack. -He ordered a heart healthy diet for Resident #4. -An all-beef hotdog, home style potato chips, sauerkraut, and fruit cobbler were not considered part of a heart healthy diet. -He expected the facility to follow physician's orders and serve Resident #4 a heart healthy therapeutic diet. Refer to the interview with the Administrator on 06/27/23 at 4:06pm. Refer to the interview with the Dietary Manager on 06/28/23 at 11:54am Refer to the interview with the Administrator on 06/29/23 at 11:54am. Interview with the Administrator on 06/27/23 at	D 296		

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D 296	Continued From page 14 4:06pm revealed: -She had never seen a therapeutic diet menu available for guidance of kitchen staff to use to prepare meals. -She did not think the menu supply company offered a heart healthy diet extension menu. -All foods listed on the regular menu were pureed for Resident #6 and not by using a diet extension menu from the facility's contracted food menu company. Interview with the Dietary Manager on 06/28/23 at 11:54am revealed: -She had never seen a therapeutic diet menu used for guidance to prepare therapeutic diets ordered for residents. -She was not formally trained for the Dietary Manager position. -All kitchen and dining room staff were trained to prepare and serve meals and drinks as ordered but did not have a therapeutic diet menu to use for guidance. Interview with the Administrator on 06/29/23 at 11:54am revealed: -The Dietary Manager printed updated therapeutic diet orders weekly and posted the orders in the kitchen for kitchen staff and servers to refer to. -She did not know the therapeutic diet menus to use for guidance by kitchen staff were available to print from the facility's contracted food menu company's website. -Any new diet orders were given to the Dietary Manager in the daily stand-up meeting with management staff. -All therapeutic diets should be prepared and served as ordered.	D 296		

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D 310	Continued From page 15	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 5 sampled residents (Resident #4 and #6) were served physician ordered therapeutic diets related to nectar thickened liquids (#6) and a heart healthy diet (#4). The findings are: Interview with the Administrator on 06/27/23 at 4:06pm revealed she did not have a policy regarding preparing or serving therapeutic diets as ordered. 1. Review of Resident #6's current FL2 dated 04/24/23 revealed: -Diagnoses included cancer of the esophagus, dementia, and Alzheimer's disease. -Regular diet was ordered. Review of Resident #6's physician's orders revealed: -There was an order dated 06/07/23 to continue a pureed diet and change Resident #6's liquids to nectar thickened liquids. -There were no other orders for a pureed diet. Review of the therapeutic diet list updated on	D 310		

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D 310	Continued From page 16 06/27/23 and posted in the kitchen revealed Resident #6's diet was listed as a pureed diet with nectar thickened liquids. Observation of the kitchen on 06/27/23 at 9:52am revealed there were no therapeutic diet menus available including a pureed diet. Interview with the Dietary Manager on 06/27/23 at 11:25am revealed: -There was no diet extensions menu available for review for therapeutic diets including a pureed diet. -The therapeutic diets were prepared by using the printed recipe and cutting up the meat for chopped meats or placing the foods in the blender for the pureed diets. Observation of Resident #6's lunch meal service on 06/27/23 at 12:00pm revealed: -A dietary aide (DA) delivered Resident #6's lunch tray which contained a pureed hot dog and bread, pureed corn, chocolate pudding, and a glass of regular tea with ice. -Resident #6 took 3 sips of the iced tea. -The DA was asked if the tea with ice was appropriate for Resident #6 and the DA picked up the glass of tea and carried it towards the kitchen. -At 12:10pm, the DA delivered a glass of thickened tea with no ice to Resident #6. -At 12:14pm, a second DA asked the first DA if she told the survey team member that Resident #6 no longer required nectar thickened liquids. -At 12:46, a second glass of regular tea with ice was delivered to Resident #6. Interview with a DA on 06/27/23 at 12:10pm revealed: -She delivered a glass of regular tea with ice to Resident #6.	D 310		

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-Resident #6 had orders for a pureed diet with nectar thickened liquids.
-She removed the glass of tea from Resident #6's lunch tray and returned it to the kitchen.
-She poured a new glass of tea for Resident #6 and added a thickening powder to make the tea a nectar thick consistency.

Interview with a second DA on 06/27/23 at 12:14pm revealed:
-Resident #6 had recently been choking on his food and drinks and vomited in his plate several times.
-She did not know if the primary care provider (PCP) changed the order from nectar thickened liquids to regular liquids.
-The therapeutic diet order list posted in the kitchen still had nectar thickened liquids ordered for Resident #6.
-The Dietary Manager updated the diet order list posted in the kitchen when new diet orders were received.
-The DAs did not thicken Resident #6's liquids for about a week because the MA supervisor instructed the dietary staff to not thicken the liquids anymore.
-She did not ask the Dietary Manager if Resident #6's liquids should be thickened since the MA said to not thicken the liquids.

Interview with Resident #6 on 06/27/23 at 12:56pm revealed:
-He got choked on liquids sometimes and the liquid would come out of his nose.
-He could not remember the last time he got choked on liquids.
-He did not know if his tea was supposed to be thickened.
-He could not tell if the first glass of tea was a thicker consistency than the second glass of tea.

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D 310	Continued From page 18 Interview with the Administrator on 06/27/23 at 4:06pm revealed: -She did not know Resident #6 had an order for nectar thickened liquids. -She had a therapeutic diet order list in her office that did not have nectar thickened liquids were ordered for Resident #6. -She worked for the facility since December 2021, and she had never seen a diet menu for therapeutic diets. -She did not think the menu supply company offered a heart healthy diet menu. -All foods listed on the regular menu were pureed for Resident #6 and not by using a pureed diet menu from the facility's contracted food menu company. Interview with the Resident Care Coordinator (RCC) on 06/27/23 at 4:42pm revealed she called the hospice registered nurse (RN) for Resident #6 on 06/27/23 and received an order clarification that Resident #6 was still ordered nectar thickened liquids. Second interview with the Dietary Manager on 06/28/23 at 11:54am revealed: -She never saw therapeutic diet menus used for guidance to prepare therapeutic diets ordered for residents. -She was not formally trained for the Dietary Manager position. -The DAs in the dining room were responsible to thicken liquids according to the resident's order. -The therapeutic diet order list was printed out weekly and if a new order was received, she updated the list as soon as the new order was given to her. -Resident #6 had an order for nectar thickened liquids and she did not know why the DAs did not	D 310		

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take Resident #6 nectar thickened tea on 06/27/23.
-The Administrator gave her the new diet orders during the daily stand-up meeting.
-When the DAs were not clear on what diet should be served to a resident, the DAs should refer to the current therapeutic diet order list or ask her.
-All kitchen and dining room staff were trained to prepare and serve meals and drinks as ordered

Telephone interview with Resident #6's hospice provider on 06/28/23 at 11:40am revealed:
-She ordered Resident #6 nectar thickened liquids on 06/07/23.
-Resident #6 had throat cancer and as the disease progressed, experienced choking on liquids.
-She expected staff to follow orders or call to clarify orders if needed.
-It was important for Resident #6 to receive the nectar thickened liquids because if the liquids were too thin, Resident #6 could aspirate which could lead to pneumonia and infection.

Interview with the Administrator on 06/29/23 at 11:54am revealed:
-The Dietary Manager printed updated therapeutic diet orders weekly and posted the orders in the kitchen.
-Any new diet orders were given to the Dietary Manager in the daily stand-up meeting with management staff.
-She did not know why Resident #6 did not receive nectar thickened liquids when it was ordered.
-The DAs should have asked the Dietary Manager if Resident #6 required nectar thickened liquids since the thickened liquids were still ordered.

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2. Review of Resident #4's current FL2 dated 02/16/23 revealed:
-Diagnoses included dementia, congestive heart failure, atrial fibrillation, hypertension, hyperlipidemia, history of a heart attack, and diabetes mellitus type 2.
-There was an order for a heart healthy diet (according to the American Heart Association, a heart healthy diet recommended low sodium, low saturated fat, and low sugar intake).

Review of the therapeutic diet list updated on 06/27/23 and posted in the kitchen revealed Resident #4 was listed as a heart healthy diet.

Observation of the kitchen on 06/27/23 at 9:52am revealed there were no therapeutic diet menus available including a heart healthy diet.

Interview with the Dietary Manager on 06/27/23 at 11:25am revealed there were no therapeutic diet menus available for review for a heart healthy diet.

Observation of Resident #4's lunch meal service on 06/27/23 at 12:00pm revealed:
-The dietary aide (DA) brought Resident #4's lunch tray consisting of an all-beef hotdog on a white bread bun, a serving of home style potato chips, a small bowl of blueberry cobbler, a small plastic bowl of sauerkraut, a glass of tea, and a glass of cranberry juice.
-It could not be determined if Resident #4 was served the correct therapeutic diet due to a heart healthy diet menu was not available for staff guidance.

Review of a summary of an American Heart Association cardiac diet from the facility's

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contracted menu company dated 2022 revealed the diet consisted of limited fats and sodium intake to reduce blood lipid and cholesterol levels as well as decrease the risk of heart disease.

Interview with the Dietary Manager on 06/27/23 at 11:25am revealed:
-There were no therapeutic diet menus available to use for guidance by kitchen staff to prepare meals including a heart healthy diet.
-She was instructed by the Administrator that the menu supplied by the facility's contracted menu company were all considered heart healthy.

Interview with the Administrator on 06/27/23 at 4:06pm revealed:
-She worked for the facility since December 2021, and she had never seen a therapeutic diet menu to be used for guidance by kitchen staff to prepare therapeutic diets.
-The regular menu supplied by the facility's contracted menu company used to have heart healthy printed on the menu but was no longer printed on the menu.
-She did not think the menu supply company offered a heart healthy therapeutic diet menu.
-She thought all meals prepared by the regular menu were considered heart healthy.

Second interview with the Dietary Manager on 06/28/23 at 11:54am revealed she had never seen a therapeutic diet menu used for guidance to prepare therapeutic diets ordered for residents.

Review of the heart healthy diet from the therapeutic diet menu dated 06/27/23 revealed:
-Resident #4 should have received a low-sodium and low-fat sandwich instead of the all-beef hotdog on a bun.
-Resident #4 should have received low-sodium

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and low-fat crackers instead of the home style potato chips.
-Resident #4 should have received low-sodium and low-fat cabbage instead of the sauerkraut.
-Resident #4 should have received a ½ cup of fruit filling instead of the fruit cobbler.
-Resident #4 should have received a green salad with no dressing.

Interview with Resident #4's primary care provider (PCP) on 06/29/23 at 10:33am revealed:
-Resident #4 had heart disease including congestive heart failure, atrial fibrillation, hyperlipidemia, hypertension, and a history of a heart attack.
-He ordered a heart healthy diet for Resident #4.
-An all-beef hotdog, home style potato chips, sauerkraut, and fruit cobbler were not considered part of a heart healthy diet.
-He expected the facility to follow physician's orders and serve Resident #4 a heart healthy therapeutic diet.
-Resident #4 not being served a heart healthy diet could cause edema (swelling), excess fluid retention from the increased sodium intake, and increase the risk of complications of Resident #4's congestive heart failure.

Second interview with the Administrator on 06/29/23 at 11:54am revealed:
-The Dietary Manager printed updated therapeutic diet orders weekly and posted the orders in the kitchen.
-Any new diet orders were given to the Dietary Manager in the daily stand-up meeting with management staff.
-She expected staff to serve therapeutic diets as ordered.

3. Review of Resident #5's FL2 dated 08/26/22

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revealed:
-Diagnoses included Alzheimer's disease, degenerative joint disease, osteoporosis, and weight loss.
-There was an order for a regular diet.

Review of Resident #5's Nurse Practitioner's (NP) order dated 11/16/22 revealed there was an order for a regular diet.

Review of Resident #5's NP order dated 03/05/23 revealed there was an order for regular diet finger food consistency.

Review of Resident #5's Care Plan dated 04/05/23 revealed the resident did not require staff assistance with eating.

Review of the facility's regular menu diet for 06/27/23 revealed green salad, all beef hotdog, home style potato chips, sauerkraut, milk, and fruit cobbler.

Review of the facility's finger food diet menu for 06/27/23 revealed all beef hot dog with bun cut in half, home style potato chips, substitute sauerkraut with a finger food, milk, and fruit cobbler served in a cone.

Observation of Resident #5 during the lunch meal and beverage service on 06/27/23 from 12:00pm to 12:45pm revealed:
-Resident #5 was served a hotdog in a bun, potato chips, sauerkraut, an ice cream sandwich, tea, milk, and water.
-Resident #5 alternated between using her fork and her hands to hold pieces of the hotdog to eat it.
-Resident #5 used a fork to eat the sauerkraut she was served.

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D 310	Continued From page 24 Interview with a personal care aide (PCA) on 06/27/23 at 12:27pm revealed: -Resident #5's diet had recently changed from a regular diet to a finger foods diet. -Resident #5 continued to use the utensils provided to eat items served to her including some finger food items. -She was not sure what substitutions were required for the finger foods diet. -The kitchen was responsible for preparing a fingerfood plate for Resident #5. -The PCA's only served the plate to the resident. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. _____ The facility failed to serve therapeutic diets as ordered including 2 glasses of non-thickened iced tea to Resident #6 with throat cancer and a history of choking and vomiting food and liquids that had an order for nectar thickened liquids increasing the risk of aspiration, infection, and pneumonia and Resident #4 who received a meal that was high fat, high sodium, high cholesterol, and high in sugar when he was supposed to be served a heart healthy diet that increased the risk of complications of congestive heart failure including edema and fluid retention. This was detrimental to the health, safety, and welfare of Resident's #4 and #6 and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 06/28/23. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 14, 2023.	D 310		

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D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#4) and 2 of 5 residents (#8 and#9) observed during medication pass regarding an order for a medication used to treat inflammation (#4), heart failure (#9), dementia (#8), and gastroesophageal reflux disease (#8). The findings are: 1. Review of Resident #4's current FL2 dated 02/16/23 revealed diagnoses included dementia, congestive heart failure, and diabetes mellitus type 2. Review of Resident #4's physician's order dated 05/10/23 revealed an order for prednisone (a medication used to treat inflammation) 10mg take 1 tablet daily.	D 344		

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Review of Resident #4's physician's order dated 05/16/23 revealed an order for prednisone 40mg take 1 tablet daily.

Review of Resident #4's local hospital discharge summary dated 05/15/23-05/17/23 revealed:
-The admitting diagnoses included heart failure.
-There was a physician's order dated 05/17/23 for prednisone 20mg with no instructions regarding quantity of tablets, route, or frequency.

Review of Resident #4's May 2023 electronic Medication Administration Record (eMAR) from 05/11/23 through 05/31/23 revealed:
-There was an entry for prednisone 10mg take 1 tablet daily.
-Prednisone 10mg was documented as administered daily at 8:00am from 05/11/23-05/15/23 and 05/18/23-05/31/23.
-There was no documentation prednisone 10mg was administered on 05/16/23 and 05/17/23 with a comment Resident #4 was out of the facility.
-There was no documentation prednisone 20mg was administered from 05/17/23 through 05/31/23.

Review of Resident #4's June 2023 eMAR from 06/01/23 through 06/28/23 revealed:
-There was an entry for prednisone 10mg take 1 tablet daily.
-Prednisone 10mg was documented as administered daily at 8:00am from 06/01/23-06/28/23.
-There was no documentation prednisone 20mg was administered from 06/01/23 through 06/28/23.

Interview with a medication aide (MA) on 06/28/23 at 12:40pm revealed:
-She administered prednisone 10mg to Resident

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#4 on 06/28/23 at 8:00am.
-She thought Resident #4's current order for prednisone was 10mg take 1 tablet daily.
-She did not know there was an order in Resident #4's record for prednisone 40mg take 1 tablet daily dated 05/16/23 or an order on the local hospital discharge summary dated 05/17/23 for prednisone 20mg with no instructions for dosage, route, or frequency.

Telephone interview with the facility's contracted pharmacy on 06/29/23 at 3:39pm revealed:
-They received an order for Resident #4 dated 03/16/23 for prednisone 5mg 1 tablet daily.
-They received a second order for Resident #4 dated 05/10/23 for prednisone 10mg 1 tablet daily.
-There were no additional prednisone orders for Resident #4.
-They dispensed 7 tablets of prednisone 10mg tablets every week from 05/10/23 to 06/28/23.
-They received a hospital discharge summary for Resident #4 on 05/17/23 with an order to continue prednisone 20mg.
-The 05/17/23 prednisone order did not provide the dosage, route of administration, or frequency of administration and it was not filled.

Interview with the Resident Care Coordinator on 06/28/23 at 3:03pm revealed:
-Resident #4 was ordered prednisone 10mg take 1 tablet daily on 05/10/23.
-The order dated 05/16/23 for Resident #4's prednisone 40mg take 1 tablet daily was not faxed to the pharmacy because the order was missing a "faxed" stamp.
-Resident #4 was sent out to the local hospital on 05/15/23 and returned to the facility on 05/17/23.
-The physician's orders from the local hospital discharge summary for prednisone 20mg with no

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instructions for quantity of tablets, route, or frequency should have been clarified by the MA with the primary care provider (PCP).
-There was no documentation in Resident #4's chart notes that the MA notified the PCP of the incomplete prednisone 20mg order dated 05/17/23.
-There were no other orders for Resident #4 clarifying the prednisone 20mg order dated 05/17/23 with instructions for route, dosage, or frequency.

Telephone interview with Resident #4's PCP on 06/29/23 at 10:33am revealed:
-Resident #4 was ordered prednisone 20mg take 1 tablet daily during a previous hospitalization around February 2023.
-Resident #4 was ordered prednisone 5mg take 1 tablet daily on 03/16/23 for respiratory congestion to decrease inflammation related to congestive heart failure.
-He increased the prednisone to 10mg daily on 05/10/23 and increased it again on 05/16/23 to 40mg daily due to increased respiratory congestion.
-Resident #4 was hospitalized on 05/15/23 for congestive heart failure exacerbation.
-The facility did not contact him to clarify the order dated 05/17/23 from the local hospital discharge summary report for Resident #4's prednisone 20mg with no route, dosage, or frequency included in the order.
-He expected staff to call and clarify medication orders if the orders were incomplete or unclear.
-It was important for Resident #4 to receive the correct dosage of prednisone since he had congestive heart failure.
-Resident #4 not receiving the correct dosage of prednisone could result in increased inflammation in the lungs or increased respiratory congestion

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which could cause Resident #4 to experience breathing difficulty and shortness of breath.

Interview with the Administrator on 06/29/23 at 11:54am revealed:
-She did not know Resident #4 had an incomplete medication order dated 05/17/23 from a recent hospitalization for prednisone 20mg with no route, dosage, or frequency included.
-The MA who received the order was responsible to fax the orders to the facility's contracted pharmacy.
-The MA should have called Resident #4's PCP to clarify the prednisone order dated 05/17/23.
-The Health and Wellness Director (HWD) was responsible for checking over the orders for residents and comparing the orders to the eMARs during eMAR audits, but the HWD position at the facility was vacant.
-The MA did not fax Resident #4's prednisone order for 40mg take 1 tablet daily dated 05/16/23 to the pharmacy since the eMAR still had prednisone 10mg take 1 tablet daily entered on the eMAR.
-She expected the MAs to fax new orders to the pharmacy and call the PCP to clarify medication orders that were incomplete or unclear.

Attempted telephone interview with the MA on 06/29/23 at 12:40pm was unsuccessful.

2. Review of Resident #9's current FL2 dated 03/29/23 revealed:
-Diagnoses included dementia, congestive heart failure, kidney disease, hypertension, and gastroesophageal reflux disease.
-There was an order for digoxin (used to help manage symptoms of heart failure) 125mcg.
-The digoxin order did not include the dosage, route of administration, or frequency of

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administration.

Review of Resident #9's FL2 dated 01/05/23 revealed there was an order for digoxin 125mcg 1/2 tablet (62.5mcg) once daily, hold for heart rate less than 50 beats per minute (bpm).

Review of Resident #9's June 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for digoxin 125mcg 1/2 tablet daily hold if pulse less than 60.
-The digoxin was documented as administered from 06/01/23 to 06/28/23 as ordered.

Observation of the 8:00am medication pass on the Special Care Unit (SCU) on 06/28/23 at 7:38am revealed:
-At 7:40am, the MA checked Resident #9's pulse and it was 62 bpm.
-At 7:45am, the MA administered digoxin 125mcg 1/2 tablet to Resident #9 in addition to the resident's other scheduled oral medications.

Interview with Resident #9's Nurse Practitioner (NP) on 06/28/23 at 9:30am revealed:
-He wrote an incomplete digoxin order on Resident #9's FL2 dated 03/29/23.
-The facility staff did not contact him for clarification of Resident #9's digoxin order on the FL2 dated 03/29/23.
-Resident #9 was supposed to receive digoxin 125mcg 1/2 tablet (62.5mcg) daily hold for heart rate less than 60 bpm.

Telephone interview with the facility's contracted pharmacy on 06/28/23 at 10:12am revealed they received an order on 05/08/23 written by Resident #9's NP for digoxin 125mcg 1/2 tab (62.5mcg) daily hold for heart rate less than 60.

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D 344	Continued From page 31 Interview with the Administrator on 06/29/23 at 11:35am revealed: -The resident's primary care provider's (PCP's) were responsible for completing the medication orders on resident FL2s. -The medication aide (MAs) were responsible to send the FL2 back to the PCP if there were incomplete orders on the FL2. -An MA should have seen the digoxin order was incomplete and sent the FL2 back to the PCP for clarification. -The MAs were responsible for faxing completed FL2's to the pharmacy. -The Health and Wellness Director (HWD) and the Resident Care Coordinator (RCC) were responsible for checking the FL2 orders and ensuring the orders were entered correctly by the pharmacy. 3. Review of Resident #8's current FL2 dated 03/15/23 revealed: -Diagnoses included dementia, hyperlipidemia, and essential hypertension. -There was an order for atorvastatin (used to lower cholesterol and triglyceride levels in the blood) 20mg 1 tablet daily. Review of Resident #8's pharmaceutical review dated 01/25/23 revealed the pharmacist recommended atorvastatin was best administered at bedtime. Review of Resident #8's Nurse Practitioner's (NP) order dated 01/25/23 revealed change time of administration of atorvastatin 20mg 1 tablet daily to 8:00pm instead of 8:00am. Review of Resident #8's June 2023 electronic Medication Administration Record (eMAR)	D 344		

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revealed:
-There was an entry for atorvastatin 20mg 1 tablet once daily at bedtime, scheduled for 8:00am.
-The atorvastatin was documented as administered from 06/01/23 to 06/28/23 at 8:00am for 26 occurrences out of 26 opportunities.

Interview with the medication aide (MA) assigned to Assisted Living (AL) during 8:00am medication pass on 06/28/23 at 8:12am revealed:
-Resident #8's atorvastatin was scheduled to be administered at 8:00pm even though the order appeared with the 8:00am medication pass.
-She held Resident #8's atorvastatin and it would be administered at 8:00pm that evening.

Observation of the MA during on AL 8:00am medication pass on 06/28/23 at 8:15am revealed Resident #8 was not administered atorvastatin.

Telephone interview with the contracted facility pharmacy on 06/28/23 at 9:00am revealed:
-They had an order for Resident #8 dated 01/25/23 for atorvastatin 20mg 1 tablet daily at 8:00pm.
-They did not receive Resident #8's FL2 dated 03/15/23 with the order to administer atorvastatin daily.

Interview with Resident #8's NP on 06/28/23 at 9:35am revealed:
-The facility staff had not contacted him concerning a clarification order for Resident #8's atorvastatin order on the 03/15/23 FL2.
-Resident #8 was supposed to receive atorvastatin 20mg daily at bedtime.
-He changed the atorvastatin 20mg daily to be administered at 8:00pm instead of 8:00am on

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D 344	Continued From page 33 01/25/23. -The atorvastatin order was incorrect on the 03/15/23 FL2. Interview with the Resident Care Coordinator (RCC) on 06/29/23 at 9:16am revealed: -She was currently responsible to audit the medication carts once a week for all residents in the facility. -The Health and Wellness Director (HWD) was responsible for medication cart audits but that position was vacated 1 and 1/2 months earlier. -Medication cart audits included going through the resident's eMARs to ensure the entries matched the orders. -A medication cart audit had not been completed since the HWD position had been vacant. Interview with the Administrator on 06/29/23 at 11:35am revealed: -The MAs were responsible for faxing completed FL2s to the pharmacy. -The HWD and the RCC were responsible for checking the FL2 orders against the orders in the eMAR to ensure the orders were correct. -The HWD and RCC were responsible for obtaining clarification of medication orders from the prescriber.	D 344		
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	D 358		

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D 358	Continued From page 34 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents observed during the medication pass (Resident #7) and 1 of 6 sampled residents (#12) related to administering medications used to treat dementia (#7) and gastroesophageal reflux disease (#7) after the orders were discontinued and not administering a mouth rinse to keep the mouth clean after oral surgery (#12). The findings are: 1. Review of Resident #12's current FL2 dated 11/18/22 revealed diagnoses included dementia, dysphagia (difficulty swallowing), and kidney disease. Interview with Resident #12's family member on 06/29/23 at 4:30pm revealed: -Resident #12 had oral surgery to extract 2 teeth on 06/23/23. -She brought back paperwork from the oral surgeon on 06/23/23 and left it on Resident #12's bed. -The oral surgeon ordered chlorhexidine 0.12% rinse (used to decrease bacteria in the mouth) to be used two times a day starting day 4 (06/27/23) after the surgery to prevent infection. -The medication aides (MAs) had not yet started Resident #12's chlorhexidine 0.12% rinse. -Resident #12's family member took the prescription for the chlorhexidine rinse to a local pharmacy, where it was filled on 06/23/23, delivered by the family member to the facility on 06/27/23.	D 358		

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-The family member told her he had given the chlorhexidine rinse to a MA on the evening of 06/27/23.

Observation of the assisted living medication room on 06/29/23 at 4:48pm revealed:
-There was an unopened bottle of chlorhexidine 0.12% rinse labeled with a computer-generated label from a local pharmacy with Resident #12's name sitting on the cabinet next to the sink.
-The label directions were swish and spit 15ml twice daily times 2 weeks, start day 4.
-The date filled was 06/23/23.

Interview with a MA on 06/29/23 at 4:50pm revealed:
-They received Resident #12's chlorhexidine rinse from a family member on 06/27/23.
-The family member did not bring an order for the chlorhexidine rinse.
-The chlorhexidine rinse could not be administered until they could get an order from Resident #12's oral surgeon.

Interview with the night shift MA on 06/30/23 at 7:38am revealed:
-She did not administer Resident #12's chlorhexidine rinse during the evening of 06/29/23.
-The chlorhexidine rinse did not appear on Resident #12's eMAR to be administered.

Observation of in the medication room on 06/30/23 at 7:39am revealed Resident #12's chlorhexidine 0.12% rinse was still unopened.

Interview with the RCC on 06/30/23 at 7:52am revealed:
-Resident 12's family member brought the chlorhexidine rinse to the facility the evening of

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06/27/23.
-The MA told the family member they needed an order when they brought the mouth rinse on 06/27/23.
-On 06/28/23, the family member returned and he gave the MA a copy of the pharmacy's information insert from the chlorhexidine, but not an order for the rinse.
-On 06/29/23, another MA called the contracted facility pharmacy, to check on the chlorhexidine rinse order entry into the eMAR.
-The facility's contracted pharmacy said they received the information insert for the chlorhexidine rinse, however they would need to get the actual prescription from the pharmacy that filled Resident 12's mouth rinse to enter it into the eMAR.
-The facility's contracted pharmacy entered the order into the eMAR in the evening on 06/29/23.

Telephone interview with Resident #12's oral surgeon's triage nurse on 06/30/23 at 8:06am revealed:
-The chlorhexidine mouth rinse was ordered for Resident #12 as a "preventative."
-The mouth rinse was ordered to keep Resident #12's mouth "clean" while the tissue healed.
-As long as Resident #12 was not having tenderness or pain at the extraction sites, the resident would be "okay."

Interview with Resident #12 on 06/30/23 at 8:54am revealed:
-Her mouth was feeling "dry."
-She could not remember if she had used the chlorhexidine mouth rinse.
-She was not having any pain or tenderness in her mouth at the extraction sites in her mouth.
-She was not experiencing difficulty eating her meals.

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D 358	Continued From page 37 Telephone interview with the facility's contracted pharmacy on 06/30/23 at 9:09am revealed: -They received a fax from the facility "late" on 06/28/23 for Resident #12. -They received a half of a page of a pharmacy informational sheet for Resident #12's chlorhexidine mouth rinse. -Early on 06/29/23, the contracted pharmacy contacted a MA at the facility and asked them to refax the informational sheet on the chlorhexidine mouth rinse. -On 06/29/23 at 4:41pm, they received a faxed copy of the pharmacy informational sheet for Resident #12's chlorhexidine mouth rinse. -The chlorhexidine mouth rinse was entered onto Resident #12's eMAR before end of business day on 06/29/23. -The chlorhexidine order entered onto the eMAR on 06/29/23 would have to be approved by facility staff before the order would become available to prompt administration. Interview with the Administrator on 06/30/23 at 9:02am revealed: -Resident #12's family took Resident #12 to the oral surgeon to have extractions. -Upon return to the facility, the family failed to provide orders to the MA's on how to care for Resident #12 after the oral surgery. -The family filled the prescription for chlorhexidine with a local pharmacy instead of using the facility's contracted pharmacy. -The RCC was not successful in getting a copy of the order from the local pharmacy. -The MAs faxed a copy of the filling pharmacy's informational sheet, so the contracted pharmacy could add the order to the eMAR. -She became aware of the situation with Resident #12's chlorhexidine mouth rinse on 06/29/23.	D 358		

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-The RCC or MAs should have contacted Resident #12' oral surgeon for copies of the post care orders.

2. The medication error rate was 7% as evidenced by the observation of 2 errors out of 29 opportunities during the 8:00am medication pass on 06/28/23.

Review of Resident #7's current FL2 dated 04/20/23 revealed diagnoses included Alzheimer's Disease, hypertension, and headaches.

a. Review of Resident #7's current FL2 dated 04/20/23 revealed there was an order for donepezil (used to treat dementia) 10mg 1 tablet daily.

Review of Resident #7's Nurse Practitioner's (NP) order dated 06/22/23 revealed an order to discontinue donepezil.

Observation of the medication pass on 06/28/23 at 8:03am revealed:
-The medication aide (MA) pulled a multi-dose package of medications for Resident #7 out of the drawer.
-The multi-dose package of morning medications for Resident #7 included one donepezil 10mg tablet.
-The MA emptied the medications into a medicine cup.
-The MA administered the medications to Resident #7.

Review of Resident #7's June 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for donepezil 10mg 1 tablet

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daily at 8:00am.
-Donepezil was documented as administered daily from 06/01/23 to 06/23/23.

Interview with the MA on 06/28/23 at 10:55am revealed:
-When a resident received discontinue medication orders, the MA who received the order would fax the order to the pharmacy.
-The pharmacy would discontinue the order on the eMAR.
-The MA was responsible to remove the discontinued medication from the multi-dose package before administering it to the resident.
-She had referred to the eMAR to administer Resident #7's morning medications, but had not noticed she needed to remove the donepezil from the multidose pack.
-The multidose packs were sent to the facility weekly.
-The new weekly multidose packs would arrive that evening (06/28/23).

Interview with the Administrator on 06/29/23 at 11:35am revealed:
-The facility's policy was to administer medications as ordered.
-The MAs were trained to properly administer medications.
-The MA should administer medications by following the orders in the eMAR and removing any medications from the multidose pack that were not on the eMAR before administering the medications.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

b. Review of Resident #7's current FL2 dated

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04/20/23 revealed there was an order for famotidine (used to treat gastroesophageal reflux disease) 20mg 1 tablet twice daily.

Review of Resident #7's Nurse Practitioner's (NP) order dated 06/22/23 revealed an order to discontinue famotidine.

Observation of the medication pass on 06/28/23 at 8:03am revealed:
-The medication aide (MA) pulled a multi-dose package of medications for Resident #7 out of the drawer.
-The multi-dose package of morning medications for Resident #7 included one famotidine 20mg tablet.
-The MA emptied the medications into a medicine cup.
-The MA administered the medications to Resident #7.

Review of Resident #7's June 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for famotidine 20mg 1 tablet twice daily at 8:00am and 8:00pm.
-Famotidine was documented as administered twice daily from 06/01/23 to 06/23/23.

Interview with the MA on 06/28/23 at 10:55am revealed:
-When a resident received discontinue medication orders, the MA who received the order would fax the order to the pharmacy.
-The pharmacy would discontinue the order on the eMAR.
-The MA was responsible to remove the discontinued medication from the multi-dose package before administering it to the resident.
-She had referred to the eMAR to administer

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D 358	Continued From page 41 Resident #7's morning medications, but had not noticed she needed to remove the famotidine from the multidose pack. -The multidose packs were sent to the facility weekly. -The new weekly multidose packs would arrive that evening (06/28/23). Interview with the Administrator on 06/29/23 at 11:35am revealed: -The facility's policy was to administer medications as ordered. -The MAs had received training on how to properly administer medications. -The MA should administer medications by following the orders in the eMAR and removing any medications from the multidose pack that were not on the eMAR before administering the medications. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.	D 358		
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 infectious diseases, each adult care home shall do all of the following: (1) Implement written infection prevention and control policies and procedures that are based on accepted national standards consistent with the federal Centers for Disease Control and Prevention	D932		

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D932	Continued From page 42 guidelines on infection control, which shall be maintained in the facility and accessible to adult care home staff working at the facility. The policies and procedures shall address 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 resident 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. g. Standard and transmission-based precautions, including the following: 1. Respiratory hygiene and cough etiquette. 2. Environmental cleaning and disinfection. 3. Reprocessing and disinfection of reusable resident devices.	D932		

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D932	Continued From page 43 4. Hand hygiene. 5. Accessibility and proper use of personal protective equipment. 6. Types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions. h. In accordance with the public health laws of North Carolina, when and how to report to the local health department a suspected or confirmed, reportable communicable disease case or condition, or a communicable disease outbreak. i. Procedures for ensuring that residents, representatives of residents, and adult care home staff are informed of the following without disclosing any personally identifiable information of the facility's residents or staff: 1. The existence of a communicable disease outbreak within 24 hours following confirmation of the outbreak by the local health department. 2. When the communicable disease outbreak has resolved. 3. Any changes to facility operations during the communicable disease outbreak, such as visitation policy changes. j. Measures the facility should consider for specific types of communicable disease outbreaks in order to prevent the spread of illness, such as: 1. Isolating infected residents. 2. Limiting or stopping group activities and	D932		

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communal dining.
3. Limiting or restricting outside visitation to the facility.
4. Screening staff, residents, and visitors for signs of illness.
5. Using source control as tolerated by the residents.
k. Strategies for addressing potential staffing issues and ensuring
adequate staffing is available to meet the needs of the residents during
a communicable disease outbreak.
(2) Require and monitor compliance with the facility's infection prevention and
control policies and procedures.
(3) Update the infection prevention and control policies and procedures as
necessary to maintain consistency with accepted national standards in infection prevention and control.
(4) Designate one on-site staff member for each noncontiguous facility who is
knowledgeable about the federal Centers for Disease Control and Prevention
guidelines on infection control to direct the facility's infection control
activities and ensure that all adult care home staff is trained in the facility's
written infection prevention and control policies and procedures
developed pursuant to subdivision (b)(1) of this section within 30 days after
hire and annually thereafter. Any nonsupervisory staff member designated to
direct the facility's infection control activities shall complete the infection
control course developed by the Department pursuant to G.S. 131D-4.5C.
(5) When a communicable disease outbreak has

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D932	Continued From page 45 been identified at a facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's infection control and prevention policies and procedures developed pursuant to subdivision (b)(1) of this section and related policies and procedures; section; provided, however, that if guidance or directives specific to a communicable disease outbreak or emerging infectious disease threat have been issued in writing by the Department or local health department, the Department's or local health department's specific guidance or directives shall be implemented by the facility. Effective January 1, 2022 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 (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 3 of 3 sampled residents (#1, #10, and #11) with orders for blood sugar monitoring resulting in shared glucometers between residents. The findings are: Observation of fingerstick blood sugar (FSBS) testing on the 200 hall by the morning medication	D932		

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D932	Continued From page 46 aide (MA) on 06/27/23 at 11:30am revealed: -The MA removed a black zippered pouch from the top drawer of the medication cart. -The zippered pouch was not labeled with a resident's name or room number. -The Brand A glucometer inside the black zippered pouch was not labeled with a resident's name or room number. -The MA donned gloves and used the proper infection prevention techniques to obtain a FSBS. -The MA returned the Brand A glucometer to the unlabeled pouch. -The MA disposed of the single use lancing device and test trip in a biohazard waste container and gloves and alcohol swab into the trash. -The MA performed hand hygiene with hand sanitizer. -There was no observation of cleaning/disinfecting the glucometer before or after use. Interview with the MA on 06/27/23 at 11:32am revealed: -The zippered pouch and glucometer inside the pouch were not labeled with a resident name or room number. -He did not know why the glucometer was not labeled with a resident name or room number. -He knew the unlabeled glucometer belonged to Resident #10, because Resident #10 was a new admission and she brought the glucometer she used at home with her to the facility. -Resident #10's zippered pouch with a glucometer was the only one that was not labeled with a room number in the medication cart. -He did not know why he nor any of the other MAs had not already labeled Resident #10's glucometer with her room number. -The facility would obtain a new glucometer and	D932		

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supplies for any resident admitted to the facility with orders for FSBS testing who did not have their own FSBS monitoring equipment and supplies.
-The four remaining zippered pouches with glucometers were labeled with resident room numbers corresponding to the residents who had orders for FSBS testing.
-Resident #10 received FSBS testing 3 times a day before meals.

Observation of the MA on 06/27/23 at 11:33am revealed the MA wrote the room number of the resident of whom he had just obtained the FSBS onto the outside of the unlabeled zippered pouch.

Review of the CDC guidelines for infection control revealed:
-Blood glucose monitoring devices (glucometers) should not be shared.
-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 not be shared.

Review of Brand A glucometer's manufacturer's product information insert revealed:
-The Brand A glucometers are for single person use.
-Do not use on multiple people.
-All parts of the kit are considered biohazardous and can potentially transmit infectious diseases, even after you have performed cleaning and disinfection.

Review of the facility's blood sugar monitoring policy (no date indicated) revealed each resident should have their own glucometer.

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1. Review of Resident #1's current FL2 dated 01/25/23 revealed diagnoses included diabetic neuropathy and hypertension.

Review of Resident #1's Nurse Practitioner's (NP) order dated 05/19/23 revealed:
-FSBS testing 3 times a day before meals and document results.
-If FSBS is less than 80 or greater than 300 notify NP.

Observation of FSBS testing on 200 hall by a morning medication aide (MA) on 06/27/23 at 11:23am revealed:
-The MA removed a black zippered storage pouch from the top drawer of the medication cart.
-The black zippered pouch was labeled with Resident #1's room number on the outside of the pouch.
-The MA donned gloves.
-The MA unzipped the pouch and the Brand A glucometer inside was not labeled with a resident's name or room number.
-The MA proceeded to obtain a FSBS test from Resident #1.
-The MA disposed of the single use lancing device and test strip in a biohazard waste container and the gloves and alcohol swabs in the trash.
-The MA returned the Brand A glucometer to the pouch labeled with Resident #1's room number and zipped the pouch.
-There was no observation of cleaning/disinfecting the glucometer before or after use.

Review of FSBS values recorded in the history of the Brand A glucometer identified as Resident #1's glucometer revealed:
-The date on the glucometer was set correctly.

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-The time on the glucometer was not set correctly.
-FSBS values recorded in the history of the glucometer from 06/01/23 to 06/27/23 were not consistent with FSBS readings documented on the resident's June 2023 electronic Medication Administration Record (eMAR).

Review of Resident #1's June 2023 eMAR revealed:
-There was an entry for FSBS 3 times a day at 8:00am, 11:30am, and 4:30pm.
-FSBS values were documented on the eMAR three times a day from 06/01/23 to 06/27/23.

Review of FSBS values recorded in the history of Resident #1's glucometer compared to the FSBS values documented on the June 2023 eMAR revealed:
-There were 80 opportunities for FSBS values documented on the eMAR from 06/01/23 to 06/27/23 at 11:30am.
-There were 35 FSBS values recorded in the history of Resident #1's glucometer from 06/01/23 to 06/27/23 with 20 values recorded in the history of the glucometer that matched FSBS values and 57 FSBS values recorded in the history of the glucometer that did not match FSBS values documented on the June 2023 eMAR.
-There were no FSBS values documented in the history of Resident #1's glucometer on 06/03/23, 06/04/23, and 06/07/23.
-On 06/01/23 at 7:36am, the FSBS 241 was recorded in the history of Resident #1's glucometer and not documented on Resident #1's eMAR with FSBS value corresponding to the same date and time documented on Resident #11's eMAR.
-On 06/02/23 at 1:46am, the FSBS 198 was recorded in the history of Resident #1's glucomter

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and not documented on Resident #1's eMAR with FSBS value corresponding to the same date and time documented on Resident #11's eMAR.
-On 06/02/23 at 7:05pm, the FSBS 269 was recorded in the history of Resident #1's glucometer and not documented on Resident #1's eMAR with FSBS value corresponding to the same date and time documented on Resident #11's eMAR.
-On 06/08/23 at 6:00am, the FSBS 294 was documented on Resident #1's eMAR and not recorded in the history of Resident #1's glucometer with an extra FSBS value corresponding to the same time and date in Resident #11's glucometer.
-On 06/08/23 at 11:30am, the FSBS 238 was documented on Resident #1's eMAR and not recorded in the history of Resident #1's glucometer with an extra FSBS value corresponding to the same time and date in Resident #11's glucometer.
-On 06/08/23 at 4:30pm, the FSBS 256 was documented on Resident #1's eMAR and not recorded in the history of Resident #1's glucometer with an extra FSBS value corresponding to the same time and date in Resident #11's glucometer.
-On 06/11/23 there were 2 FSBS recorded in the history of Resident #1's glucometer separated by 2 minutes, with 1 value documented on Resident #1's eMAR.
-On 06/25/23, there were 4 FSBS values recorded in the history of the glucometer with 1 value that did not match FSBS values documented on the June 2023 eMAR.

Interview with Resident #1 on 06/28/23 at 3:56pm revealed:
-Staff checked her FSBS three times a day.
-Staff used a disposable lancet to obtain the

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blood samples for the FSBS checks.
-Staff kept the equipment and supplies used to check her FSBS on the medication cart.

Refer to the interview with a MA on 06/27/23 at 3:40pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/27/23 at 4:00pm.

Refer to the interview with the RCC on 06/29/23 at 9:16am.

Refer to the interview with the Nurse Practitioner (NP) on 06/29/23 at 10:33am.

Refer to the interview with the Administrator on 06/29/23 at 11:35am.

2. Review of Resident #10's current FL2 dated 06/07/23 revealed diagnoses included diabetes and hypertension.

Review of Resident #10's Nurse Practitioner's (NP) order dated 06/07/23 revealed:
-FSBS testing 3 times a day before meals and document results.
-If FSBS is less than 80 or greater than 300 notify NP.

Observation of the medication aide (MA) on 06/27/23 at 11:30am revealed:
-The MA located a Brand A glucometer in an unlabeled zippered pouch in the top drawer of the medication cart.
-The MA donned gloves.
-The MA unzipped the pouch and the Brand A glucometer inside was not labeled with a resident's name or room number.
-The MA proceeded to obtain a FSBS test from

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Resident #10.
-The MA disposed of the single use lancing device and test strip in a biohazard waste container and the gloves and alcohol swabs in the trash.
-The MA returned the Brand A glucometer to the unlabeled pouch and zipped the pouch.
-There was no observation of cleaning/disinfecting the glucometer before or after use.

Interview with the medication aide (MA) on 06/27/23 at 11:34am revealed:
-Resident #10 was newly admitted to the facility.
-Resident #10 did not have a black zippered pouch labeled with her room number.
-He knew the unlabeled glucometer belonged to Resident #10, because it was the only zippered pouch with a glucometer that was not labeled with a room number.
-The four remaining zippered pouches with glucometers were labeled with resident room numbers corresponding to the residents who had orders for FSBS testing.
-He always used the unlabeled glucometer to obtain Resident #10's blood sugar.

Observation of the MA on 06/27/23 at 11:35am revealed he proceeded to hand write Resident #10's room number with a permanent marker on the outside of the previously unlabeled black zippered pouch.

Review of FSBS values recorded in the history of the Brand A glucometer identified as Resident #10's glucometer on 06/27/23 at 12:50pm revealed:
-The date and time on the glucometer were set correctly.
-FSBS values recorded in the history of the

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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 53	D932		

glucometer from 06/08/23 to 06/26/23 were not consistent with FSBS readings documented on the resident's June 2023 electronic medication administration record (eMAR).

Review of Resident #10's June 2023 eMAR revealed:
-There was an entry for FSBS checks three times a day before meals at 8:00am, 11:30am, and 4:30pm.
-FSBS values were documented on the eMAR 3 times a day from 06/08/23 to 06/27/23.

Review of Resident #10's FSBS values recorded in the history of Resident #10's glucometer compared to the FSBS values documented on the June 2023 eMAR revealed:
-There were 57 opportunities for FSBS values documented on the eMAR from 06/08/23 to 06/27/23.
-There were 16 FSBS values recorded in the history of Resident #10's glucometer from 06/08/23 to 06/26/23 with 13 FSBS values recorded in the history of the glucometer that matched FSBS values recorded on the June 2023 eMAR.
-There were no FSBS values documented in the history of Resident #8's glucometer on 06/09/23, 06/10/23, 06/11/23, 06/12/23, 06/14/23, 06/15/23, 06/16/23, 06/17/23, 06/18/23, 06/20/23, 06/21/23, 06/22/23, 06/23/23, and 06/24/23 with FSBS values documented on the June 2023 eMAR.

Interview with Resident #10 on 06/27/23 at 4:14pm revealed:
-She received FSBS testing once a day or twice a day.
-She did not receive FSBS testing 3 times a day.
-The number of FSBS tests each day depended on the staff who worked.

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	HAL075010	A. BUILDING: _____ B. WING _____	R-C 06/30/2023

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D932	Continued From page 54 -She did not know which glucometer staff used to check her FSBS. Refer to the interview with a MA on 06/27/23 at 3:40pm. Refer to the interview with the Resident Care Coordinator (RCC) on 06/27/23 at 4:00pm. Refer to the interview with the RCC on 06/29/23 at 9:16am. Refer to the interview with the Nurse Practitioner (NP) on 06/29/23 at 10:33am. Refer to the interview with the Administrator on 06/29/23 at 11:35am. 3. Review of Resident #11's current FL2 dated 02/21/23 revealed diagnoses included diabetes mellitus type 2. Review of Resident #11's Nurse Practitioner's (NP) order dated 05/19/23 revealed: -There was an order to check fingerstick blood sugars (FSBS) three times a day before meals. -If the FSBS was less than 80 or greater than 300 notify the NP. Observation of Resident #11's Brand A glucometer on 06/27/23 at 3:30pm revealed: -There was a black zippered pouch labeled with Resident #11's room number. -Inside the black zippered pouch was an unlabeled Brand A glucometer. Review of Resident #11's glucometer history compared to the eMARs for June 2023 revealed: -The date and time were incorrect when the glucometer was turned on and read 06/13/23 at	D932		

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D932	Continued From page 55	D932		

10:17pm.
-There were 39 FSBS readings ranging from 102 to 460 in the glucometer's history with dates ranging from 02/07/23 at 7:49pm through 06/13/23 at 10:17pm.
-There were 4 days in the glucometer history with FSBS readings 3 times a day.
-There were 5 days in the glucometer history with FSBS readings 2 times a day.
-There were 17 days in the glucometer history with FSBS readings once a day.
-On 06/12/23 at 5:37pm, the FSBS result in the glucometer was 221 which did not correspond to any readings documented on Resident #11's eMAR for June 2023.
-There was one FSBS value missing from Resident #11's glucometer history on 06/01/23 at 6:00am that corresponded to FSBS values recorded in Resident #1's glucometer history.
-There were 2 FSBS values missing from Resident #11's glucometer history on 06/02/23 at 6:00am and 4:30pm that corresponded to FSBS values recorded in Resident #1's glucometer history.

Review of Resident #11's 06/01/23 through 06/29/23 eMAR revealed:
-There was an entry for FSBS checks 3 times a day before meals at 6:00am, 11:30am, and 4:30pm and notify the NP if the reading was less than 80 or greater than 300.
-There were FSBS documented on 06/01/23 as 333 at 7:30am, 299 at 11:30am, and 298 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history.
-There were FSBS documented on 06/02/23 as 241 at 7:30am, 198 at 11:30am, and 269 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history.
-There were FSBS documented on 06/03/23 as

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D932	Continued From page 56 278 at 7:30am, 299 at 11:30am, and 288 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history. -There were FSBS documented on 06/04/23 as 299 at 7:30am, 297 at 11:30am, and 298 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history. -There were FSBS documented on 06/05/23 as 299 at 7:30am, 289 at 11:30am, and 300 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history. -There were FSBS documented on 06/06/23 as 302 at 7:30am, 300 at 11:30am, and 299 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history. -There were FSBS documented on 06/07/23 as 299 at 11:30am that did not correspond to any of the FSBS readings in the glucometer's history. -There were FSBS documented on 06/08/23 as 258 at 7:30am that did not correspond to any of the FSBS readings in the glucometer's history. -There were FSBS documented on 06/09/23 as 300 at 7:30am, 299 at 11:30am, and 388 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history. -There were FSBS documented on 06/10/23 as 244 at 11:30am, and 300 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history. -There were FSBS documented on 06/11/23 as 300 at 11:30am, and 303 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history. -There were FSBS documented on 06/12/23 as 301 at 11:30am, and 300 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history. -There were FSBS documented on 06/14/23 as 300 at 7:30am, 299 at 11:30am, and 299 at 4:30pm that did not correspond to any of the	D932		

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FSBS readings in the glucometer's history.
-There were FSBS documented on 06/15/23 as 299 at 11:30am and 298 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history.
-There were FSBS documented on 06/16/23 as 278 at 11:30am and 300 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history.
-There were FSBS documented on 06/17/23 as 299 at 7:30am, 300 at 11:30am, and 301 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history.
-There were FSBS documented on 06/18/23 as 299 at 7:30am, 300 at 11:30am, and 299 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history.
-There were FSBS documented on 06/21/23 as 299 at 11:30am and 300 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history.
-There were FSBS documented on 06/22/23 as 311 at 6:00am and 300 at 4:30pm that did not correspond to any of the FSBS readings in the glucometer's history.
-There were FSBS documented on 06/24/23 as 290 at 11:30am and 288 at 4:30pm that did not correspond to any of the readings on the glucometer's history.
-There was a FSBS reading documented as 198 on 06/26/23 at 4:30pm which did not correspond to any of the readings on the glucometer's history.

Refer to the interview with a medication aide (MA) on 06/27/23 at 3:40pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/27/23 at 4:00pm.

Refer to the interview with the RCC on 06/29/23

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D932	Continued From page 58 at 9:16am. Refer to the interview with the Nurse Practitioner (NP) on 06/29/23 at 10:33am. Refer to the interview with the Administrator on 06/29/23 at 11:35pm. _____ Interview with a MA on 06/27/23 at 3:40pm revealed: -Every resident with FSBS orders had their own glucometer stored in the medication cart. -He never shared glucometers when checking resident FSBS. Interview with the Resident Care Coordinator (RCC) on 06/27/23 at 4:00pm revealed: -Every resident with orders for FSBS testing had their own FSBS testing supplies including a glucometer, test strips, and single-use lancets which were stored in the top drawer of the assisted living medication cart. -The MAs, RCC, and Health and Wellness Director (HWD) were responsible for ensuring resident glucometers and equipment were labeled appropriately. -The MAs received training to never share glucometers between residents. Interview with the RCC on 06/29/23 at 9:16am revealed: -The HWD would have been responsible for auditing the glucometer histories against the eMARs. -The prior HWD left about 6 weeks prior. -She did not know if the HWD audited the glucometer histories. Interview with the Nurse Practitioner (NP) on 06/29/23 at 10:33am revealed:	D932		

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D932	Continued From page 59 -He was not notified by the facility that glucometers were being used between multiple residents. -He did not know what the Centers for Disease Control (CDC) recommendations were regarding single person use glucometers. -If Brand A's glucometer manufacturer recommended glucometers not be shared between residents, he expected the facility to adhere to the manufacturer's recommendations. Interview with the Administrator on 06/29/23 at 11:35am revealed: -She was not aware there was a glucometer on the medication cart that was unlabeled until it was brought to her attention on 06/27/23. -The MAs, RCC, HWD, and Administrator were all responsible for ensuring glucometers were clearly labeled with resident names and room numbers. -She did not know why the glucometer pouches were only labeled with room numbers rather than resident names. -She did not know if glucometer histories were being audited. -She thought glucometer audits occurred once a month during the medication cart audits. -The MAs received training on how to properly perform FSBS testing by the contracted pharmacy's Registered Nurse (RN) prior to performing FSBS testing in the facility. -The MAs were trained to never share glucometers. --- The facility failed to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines for finger stick blood sugar checks which placed the residents at risk for possible exposure and transmission of blood borne pathogens by sharing glucometers	D932		

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D932	Continued From page 60 between Residents #1 and #11. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/27/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 14, 2023.	D932		