STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 06/12/2018

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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
{C 000}	Initial Comments The Adult Care Licensure Section and the Robeson County Department of Social Services conducted a follow-up survey from 06/11/2018 - 06/12/2018 with an exit conference conducted by telephone on 06/12/18.	{C 000}		
{C 074}	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure the walls and floors in four residents' rooms, the floors in the short hallway, the floors, exterior door and light fixture in the hallway leading to the residents' rooms and the floors in the common bathroom, the common living room and the residents' dining room were kept clean and in good repair. The findings are: Observations of the common living room and small hallway on 06/11/2018 at 9:16 a.m. revealed: -There was a grey colored stain that was approximately 8 feet long in length in a curved type pattern on the floor located in front of the doorway to the dining room that extended into a small hallway on the right side of the common living room.	{C 074}		

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{C 074}	Continued From page 1 -There was a second grey colored stain that was approximately 3 feet long in length on the floor in front of a chair in the common living room. -There was a third grey colored stain that was approximately 3 inches long and 2 inches wide on the floor at the entrance to the hallway leading to residents' rooms. Observation of the facility's hallway leading to the residents' rooms on 06/11/2018 at 9:42 a.m. and 10:07 a.m. revealed: -There was one acorn shaped ceiling light fixture globe with a thick accumulation of a spider like webbing with at least 3 insect carcasses inside of the web that surrounded the base of the globe. -There was an exterior door at the end of the hallway with small scattered indented areas and missing white paint that exposed the door's dull grey color under layer surface. Observation of resident room #1, the last resident room on the right side of the hallway on 06/11/2018 at 9:46 a.m. revealed: -There were scattered rust colored stains on the floor beside of a nightstand located on the left side of the bedroom entrance. -There were approximately 10 square floor tiles with multiple scratches with a worn surface that exposed the floor's dull grey color under layer surface. -There were scattered grey discolored areas on the surface of the floor covering throughout the room. -There was a light tan and grey discoloration along all of the edges of the floor. -The lower section of the bedroom door had a black colored scuff mark across the width of the door and a blue colored scuff mark that was approximately two 2 feet long. -The mini blind covering the window had brown	{C 074}		

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{C 074}	Continued From page 2 colored, rough stains scattered across all of the slats. Observation of resident room #2 on the left of the hallway on 06/11/2018 at 9:59 a.m. revealed -There was a build-up of yellow and brown colored stains and debris approximately one foot from the wall along all of the edges of the floor with a heavy concentration under and around the bed, nightstand, and a chest of drawers. -The closet room door had scattered brown grimy marks around the door handle and missing white paint that exposed a brown colored under layer surface. -There was a heavy build-up of a white gray dust material on the bed's head board. -There was a nightstand with a heavy build-up of dust on the lower shelf. -There were scattered brown colored marks on the walls throughout the room. Attempted interview with the resident assigned to the last resident room on the left of the hallway on 06/11/2018 at 12:35 p.m. was unsuccessful. Observation of resident room #3 on the left side of the hallway on 06/11/2018 at 9:38 a.m. revealed -There was a light tan discoloration on the floor covering that extended approximately 4 inches from the wall. -The ceiling fan had a thick layer of dust accumulation on all four blades. Interview with the resident assigned to the third resident room on the left side of the hallway on 06/11/2018 at 9:35 a.m. revealed: -He had not seen anyone clean the ceiling fan since he had lived at the facility for the last two years.	{C 074}		

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{C 074}	Continued From page 3 -The live-in personal care aides (PCAs) did clean his room daily by mopping and wiping off the top of dresser. Observation of resident room #4 on the left side of the hallway at 10:06 am. revealed: -The wall on the right side of the room had multiple grey colored grimy stains and scattered black scuff marks. -There was a light beige discoloration along the edges of the floor. Observation of the common bathroom on 06/11/18 at 10:04 a.m. revealed: -There was an uneven surface of a thick and cracked black/gray colored hard rubber type material along the edges of the right and back corners of the tiled shower stall floor that extended upward along the right and back side of the walls that varied in height from approximately 4 inches to 24 inches from the floor. -The same black/gray hard rubber type material covered the edges of the tiled floor between the bathtub and outer wall of the shower stall and extended approximately 4 inches up the wall. -There was a grey and white substance or stain scattered across the base of the sink's metal type faucet. Observation in the residents' dining room on 06/11/2018 at 10:09 a.m. revealed there was a grey colored stain on the floor that was approximately one foot long in length on the left side of the residents' dining room table. Interview with the live-in personal care aide (PCA) on 06/11/2018 at 2:35 p.m. revealed: -The facility did not have a written deep cleaning schedule. -She cleaned in areas of the facility when she	{C 074}		

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{C 074}	Continued From page 4	{C 074}		

seen they needed it.
-She performed deep cleaning every week which included cleaning out closets, window seals and cleaning the windows.
-The discolored areas and stains on the floors in the residents' rooms was from a wax build-up.
-The floors needed to be done with a steamer and a buffer.
-She mopped every room, every day, but the stained, discolored areas would not come up with regular mopping.
-She had never seen the floors in the facility steamed cleaned and buffed since she had worked at the facility for the last two years.
-She was responsible for cleaning three residents' rooms (resident rooms were named).
-She last performed a deep cleaning approximately two months ago because she was on vacation for two weeks in May 2018.
-She last cleaned the ceiling fan in the third resident room on the left side of the hallway about two months ago.
-She thought the other live-in PCAs did not do deep cleaning like they should.
-The facility had a cleaning check list form that was used during staff shift changes to report any areas in the facility that had not been cleaned by the prior staff. The form was filled out by the live-in PCAs and given to the supervisor in charge (SIC).

Interview with the SIC on 06/11/2018 at 3:40 p.m. revealed:
-All live-in PCAs were assigned cleaning duties for two residents' rooms each shift.
-Cleaning duties included sweeping under the residents' beds, dusting behind the furniture by moving the furniture, dusting ceiling fans and mopping.
-The same resident rooms had been assigned to

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{C 074}	Continued From page 5 the same live-in PCAs for the last 6 months. Telephone Interview with the SIC on 06/12/2018 at 3:35 p.m. revealed: -The live- in PCAs were responsible to report any housekeeping tasks not done from the previous live- in PCA at the time of their shift change by completing the cleaning check list form. -She had not received any cleaning check list forms or any verbal reports of needed cleaning issues lately from the live-in PCAs. -She checked the cleanliness of the facility after each shift change on Monday, Wednesday and Friday. -She had to remind the live-in PCAs about the cleanliness of the ceiling fans, baseboards and the need for dusting about 1 ½ weeks ago. -The resident assigned to the last resident room on the left of the hallway did like staff in his room and staff had to clean his room when they could "catch" him outside. The live-in PCA assigned to his room usually kept his room cleaned. -The resident assigned to the last room on the right of the hallway had caused the damage to the exterior door at the end of the hallway with his wheelchair rubbing against the door. -The scuffed areas on the exterior door at the end of the hallway had been there a couple of months or longer and was reported to the part time maintenance person about a month ago; the work to the door had not been done yet. Telephone interview with the Administrator on 06/12/20178 at 4:25 p.m. revealed: -The stains on floors in the dining room, common living area, and small hallway looked like something had been spilled. She had checked with all staff and no one knew what it was. -They had tried to remove the grey colored stains but nothing had worked to remove the stains on	{C 074}		

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{C 074}	Continued From page 6 the floor. -The floor discoloration in the residents' rooms was wax build-up and glue and the floors needed to be stripped. -She had been planning to get the floors buffed in the facility but all the residents would have to stay off the floor for 3 to 4 hours. -She had not scheduled the stripping and buffing for the floors yet because of other expensive repairs she was currently having done. -She had planned to have work done to the shower in the common bathroom. -She had to do one large expense at a time and had not scheduled the repair of the shower in the common bathroom, but was hoping to do so next month. -She had last observed the resident's room on the left side of the hallway about 2 to 3 weeks ago with the live-in PCA (named), the head board of the bed, the areas behind the bed and under the chair had been cleaned. -She performed walk-throughs of the facility weekly and she never thought about looking up (toward the ceiling fans). -Staff were assigned two resident rooms weekly to do the dusting, cleaning the mini blinds, and moving furniture to clean behind the furniture. -All live- in PCAs were assigned to clean the residents' common areas. -When she performed walk-throughs of the facility, and seen any cleaning issues, she would ask the live- in PCA to do the needed task. -She was responsible for planning and scheduling all repairs for the facility.	{C 074}		
{C 076}	10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and	{C 076}		

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{C 076}	Continued From page 7 Furnishings (a) Each family care home shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the furniture in two resident rooms and the common living area was in good repair. The findings are: Observation of the third resident room on the left side of the hallway on 06/11/2018 at 9:38 a.m. revealed: -There was a nightstand with missing wood stain in various places with a heavier concentration across the top that exposed the under layer color of the wood. -There was a 4 drawer chest of drawers that was missing 2 of 6 knobs. Observation of the last resident room on the left side of the hallway on 06/11/2018 at 10:00 a.m. revealed there was a nightstand with a faded brown wood stain around the drawer's knob and a cracked, rough wood stain surface across the lower shelf and base. Attempted interview with the resident assigned to the last resident room on the left of the hallway on 06/11/2018 at 12:35 p.m. was unsuccessful. Interview with a live-in Personal Care Aide (PCA) on 06/11/2018 at 10:00 a.m. revealed: -The Administrator or the Supervisor-in-Charge (SIC) walked through and monitored the home every week for needed furniture repairs.	{C 076}		

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{C 076}	Continued From page 8 -Some of the furniture in the home had been repaired. -The resident assigned to the last room on the left did not like anyone to be in his room, anything to be "touched" or done much in his room. Telephone Interview with the SIC on 06/12/2018 at 3:35 p.m. revealed they were working on finding affordable replacements for the nightstands that needed to be replaced in the residents' rooms. Telephone interview with the Administrator on 06/12/20178 at 4:25 p.m. revealed: -She was responsible for planning and scheduling all repairs for the facility. -She had priced nightstands for the residents' rooms and had planned to have the nightstands replaced by next weekend. -She would purchase the needed hardware for the missing knobs to the chest of drawers in the third resident room on the left side of the hallway.	{C 076}		
{C 284}	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family 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: Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 3 residents sampled (#2) who was ordered a no added salt (NAS), chopped meat diet.	{C 284}		

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{C 284}	Continued From page 9 The findings are: Review of Resident #2's current FL-2 dated 12/04/2017 revealed: -Diagnosis included severe alcohol use history, tobacco use, coronary obstructive pulmonary disease, coarctation of the aorta and hypertension. -There was an order for a no added salt (NAS) diet. Review of a physician's order dated 02/22/2018 revealed there was a diet order for a NAS, "chopped meats". Review of the diet list posted on the refrigerator on 06/11/2018 revealed Resident #2 was on a NAS, chopped meat diet. Review of the "Week One, Monday" therapeutic diet spreadsheet menu revealed the lunch meal for a NAS diet on Monday (06/11/2018) was 3 ounces of barbecue chicken, ½ cup of rice, ½ cup squash, 1 biscuit, ½ cup fruit cocktail, one teaspoon of margarine and one cup of coffee/tea/water. Observation of Resident #2 during the lunch meal on 06/11/2018 at 11:59 a.m. revealed: -The resident was served baked chicken (bone-in) that was not chopped, rice and gravy, bread, corn, 4 whole pieces of fried shrimp, ½ cup of mangos and approximately 8 ounces of tea. -At 12:08 p.m. the resident was eating the shrimp by picking the shrimp up with his hands. -At 12:11 p.m. the resident was picking up the piece of chicken and tearing the meat away from the bone as he bit into the meat.	{C 284}		

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{C 284}	Continued From page 10 -The resident started to cough. -After notification, the live-in personal care aide (PCA) cut the chicken up into bite size pieces. -The resident continued to have an occasional cough during the meal. -The resident ate 100% of his food. Interview with the live-in PCA on 06/11/2018 at 12:21 p.m. revealed: -She had forgot to chop Resident #2's meats for the lunch meal on 06/11/2018. -Resident #2's meats had to be cut up because he ate too fast. -It was not unusual for Resident #2 to cough because he always coughed a lot. Interview with Resident #2 on 06/11/2018 at 9:40 a.m. revealed: -Staff always cut his meat up for him. -He was not sure why they cut his meats up because he did not have a problem with chewing, swallowing, or getting choked. Review of the "Week One, Monday" therapeutic diet spreadsheet menu revealed the supper meal for a NAS diet on Monday (06/11/2018) was ¾ cup of spaghetti with 2 ounces of meatball sauce, ½ cup of green beans, 1 dinner roll, ½ cup applesauce, one teaspoon of margarine, one cup of milk, and coffee/tea/water. Observation of Resident #2 during the supper meal on 06/11/2018 at 5:30 p.m. revealed: -The resident was served spaghetti with 4 meatballs that were not cut up, green beans, bread, water and tea. -The resident pushed the 4 meatballs to the side of his plate. -The resident coughed several times during the meal.	{C 284}		

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{C 284}	Continued From page 11 -The resident ate approximately 75% of his meal and did not eat the four meatballs. A second interview with Resident #2 on 06/11/2018 at 5:43 p.m. revealed: -He could have eaten the meatballs if he wanted them but didn't because he had them before and they tasted like they came from a can. -He had an occasional cough at times. -He did not have a problem with eating meats. -He did not get strangled when he ate his meals. Interview with the Administrator on 06/11/2018 at 5:45 p.m. revealed: -Resident #2 had always coughed since he had lived at the facility. -Resident #2 was not aspirating. -She could not remember why he was placed on a chopped meat diet but he had always been on chopped meats with NAS. -She expected staff to chop all of the meats served to Resident #2 as ordered. Telephone interview with the Administrator on 06/12/2018 at 4:45 p.m. revealed she would contact Resident #2's primary care provider (PCP) to get clarification why he was on a chopped meat diet. Attempted telephone interview with Resident #2's PCP at 4:47 p.m. on 06/11/2018 and at 8:53 a.m. on 06/12/2018 was unsuccessful.	{C 284}		
{C 330}	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications,	{C 330}		

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{C 330}	Continued From page 12	{C 330}		

prescription and non-prescription and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE A1 VIOLATION
The Type A1 violation is abated. Non-compliance continues.

Based on record reviews and interviews, the facility failed to administer medications as ordered to 1 of 3 sampled residents (#2) with an order to discontinue a medication used to treat high blood pressure.

The findings are:

Review of Resident #2's current FL-2 dated 12/04/2017 revealed:
-Diagnosis included severe alcohol use history, tobacco use, coronary obstructive pulmonary disease, coarctation of the aorta and hypertension.
-There was an order for Hydrochlorothiazide (a medication used to treat high blood pressure and excess fluid) 12.5 mg one daily.
-There was an order to check the resident's blood pressures daily.

Review of Resident #2's March 2018 blood pressure logs revealed:
-There was documentation the resident's blood pressure was taken from 03/01/2018 - 03/31/2018.
-There was documentation the resident's lowest blood pressure readings were 96/63 on 03/08/2018, 93/87 on 03/13/2018, 88/63 on

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{C 330}	Continued From page 13 03/14/2018, 93/82 on 03/15/2018 and 86/59 on 03/27/2018. Review of a primary care provider's (PCP's) visit note for Resident #2 dated 04/19/2018 revealed: -Some hypotensive episodes had been noted. -There was an order to discontinue Hydrochlorothiazide. Review of Resident #2's April 2018 medication administration record (MAR) revealed: -There was a computer generated entry for Hydrochlorothiazide 12.5mg take one daily with a scheduled administration time at 8:00 a.m. There was one handwritten diagonal line drawn thru the entry. -There was documentation that Hydrochlorothiazide had been administered from 04/01/2018 - 04/26/2018. -There was a handwritten entry "04/19/18" documented below the daily administration spaces. There was a handwritten entry of "D/C" with the supervisor in charge's (SIC's) initials that was documented over the filled in spaces for the documented administered doses from 04/20/2018 - 04/26/2018. -There was no additional documentation that Hydrochlorothiazide had not been administered from 04/20/2018 - 04/26/2018. Review of Resident #2's April 2018 blood pressure logs revealed: -There was documentation the residents blood pressure was taken daily from 04/01/2018 - 04/29/2018 (there were two entries for 04/29/2018). -The resident's systolic blood pressure was documented as ranging from 107 - 138 and the diastolic blood pressure ranged from 58- 85 from 04/20/208- 04/29/2018.	{C 330}		

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{C 330}	Continued From page 14 Interview with the SIC on 06/11/2018 at 6:00 p.m. revealed: -She had added the handwritten entry on Resident #2's April 2018 MAR when the PCP discontinued Hydrochlorothiazide 12.5 mg. -She was not sure why there was documentation that Hydrochlorothiazide 12.5 mg had been administered from 04/20/2018 - 04/26/2018. -When a medication was discontinued the mediation was immediately pulled from the medication cart and was sent back to the pharmacy with documentation that the medication has been returned. -She would look for the copy of the medication return form that would show when the Hydrochlorothiazide for Resident #2 was returned to the pharmacy. -When a medication was not administered, the medication aide (MA) should place a circle around their initials on the day the medication was not administered and the reason the medication was not administered would have been documented on the back of the MAR. Telephone interview with a lead pharmacy technician with the facility's contracted pharmacy provider on 06/12/2018 at 9:16 a.m. revealed: -Resident #2's Hydrochlorothiazide 12.5mg was returned to the pharmacy 05/12/2018 or 05/18/2018 (he was unable to tell which date was correct due to the handwriting). -The pharmacy received an order from the PCP on 04/20/2018 to discontinue Hydrochlorothiazide 12.5 mg for Resident #2. -The medication was prescribed to Resident #2 for hypertension. - Resident #2 was at risk for lowered blood pressure levels if Hydrochlorothiazide 12.5 mg was administered 7 days after the PCP provider	{C 330}		

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{C 330}	Continued From page 15	{C 330}		

discontinued the medication. Low blood pressure levels could cause heart arrhythmia.

Review of a faxed labeled with the facility's named contracted pharmacy revealed:
-There was an entry for Resident #2's Hydrochlorothiazide 12.5 mg with a quantity of 72 and "D/C" was the reason for return.
-The bottom of the form was signed and dated by the SIC on 05/12/2018.

Attempted telephone interview with a medication aide (MA) on 06/12/2018 at 11:08 a.m. was unsuccessful.

Attempted telephone interview with a second MA on 06/12/2018 at 11:11 a.m. was unsuccessful.

Telephone interview with the SIC on 06/12/2018 at 3:35 p.m. revealed:
-Some of the initials documented on Resident #2's April 2018 MAR for Hydrochlorothiazide 12.5 mg daily was her initials after 04/19/2018.
-She could not remember if the medication was actually given after 04/19/2018.

Telephone interview with the Administrator on 06/12/2018 revealed:
-She expected for discontinued medications to be immediately removed from the medication cart.
-Medication was not immediately returned to the pharmacy when an order was written to discontinue a medication.
-She could not explain why Resident #2 had documentation that Hydrochlorothiazide was administered and a handwritten entry was documented over the administration times in large print "DC" with the SIC's initials from 04/20/2018 - 04/26/2018.
-She could not determine that Resident #2 had

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{C 330}	Continued From page 16 not received Hydrochlorothiazide after it was discontinued on 04/19/2018. Attempted telephone interview with Resident #2's PCP at 4:47 p.m. on 06/11/2018 and at 8:53 a.m. on 06/12/2018 was unsuccessful.	{C 330}		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents were free of neglect as related to adult care home infection prevention requirements. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure infection control procedures were followed as evidenced by glucometers not being labeled for 2 of 2 sampled residents (#1 and #3) with orders for blood sugar monitoring resulting in the shared use of glucometers. [Refer to Tag 0932 G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (Type B Violation].	C 914		
C 932	G.S. 131D 4.4A (b) ACH Infection Prevention Requirements 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of	C 932		

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C 932	Continued From page 17 the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record	C 932		

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C 932	Continued From page 18 reviews, the facility failed to assure infection control procedures were followed as evidenced by glucometers not being labeled for 2 of 2 sampled residents (#1 and #3) with orders for blood sugar monitoring resulting in the shared use of glucometers. The findings are: Review of the CDC (Centers for Disease Control and Prevention) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Observation on 06/11/18 at 1:50 p.m. revealed: -There was a plastic storage container with 2 different brands of glucometers stored inside. -Neither glucometer was labeled with a resident's name. Review of the owner's manual for a glucometer identified by live-in staff as Resident #1's (Brand A) glucometer revealed: -The glucometer is "for single patient use only". -"Do not share with anyone". -"Do not use on multiple patients". -All parts of the glucose monitoring system are considered biohazardous and could potentially transmit infectious diseases, even after cleaning and disinfection. -Device should not be used to collect blood from more than one person as this poses a risk of transmitting blood-borne pathogens such as Hepatitis B or HIV.	C 932		

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C 932	Continued From page 19 -If the meter is being operated by a second person who provides testing assistance, the meter and lancet device should be decontaminated prior to use by the second person. -There were no further instructions on how to decontaminate the meter. Review of the owner's manual for a glucometer identified by live-in staff as Resident #3's (Brand B) glucometer revealed: -The glucometer is "intended to be used by a single person". -The glucometer "should not be shared". -During normal testing, any blood glucose meter or lancing device may come in contact with blood. -All parts of the meter are considered biohazardous and can potentially transmit infectious disease from blood-borne pathogens, even after cleaning and disinfecting have been performed. -"Do not share the meter and lancing device with anyone, including family members, due to the risk of infection from blood-borne pathogens". -"Do not use on multiple patients!" -Cleaning and disinfecting the meter destroys most, but not necessarily all, blood-borne pathogens. -Wash hands thoroughly before and after handling the meter, lancing device, or test strips. -If the meter is being operated by a second person who is providing testing assistance, the meter and lancet device should be disinfected prior to use by the second person. -Disinfect the meter and lancing device before allowing anyone else to handle them. -Do not allow anyone else to test with the meter or lancing device. -It is important to keep the meter and lancing device clean and disinfected.	C 932		

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C 932	Continued From page 20 -Clean and disinfect the meter with only "Super Sani Cloth". -Do not use any other cleaning or disinfecting solutions. -Clean and disinfect the meter at least once per week. 1. Review of Resident #1's current FL-2 dated 1/29/18 revealed: -Diagnoses included schizoaffective disorder, diabetes mellitus, gastro esophageal reflux disease, hypertension, hypothyroidism, and hyperlipidemia. -An order to check fingerstick blood sugar (FSBS) daily. Review of the memory data of a glucometer identified as Resident #1's (Brand A) glucometer on 6/11/18 at 3:50 p.m. revealed: -The date and time on the glucometer was not set to the current date and time. The date in the meter was 4/4 and time was 5:25am (there was no year documented). -There were 33 readings in the memory data of the glucometer dated between 4/3 - 6/1. -The first three readings in the memory data were for the month of April (4/1 - 4/3). -The next seven readings in the memory data were for the month of March (3/23 - 3/31). -The next 23 readings in the memory data were for the month of June (6/1 - 6/27). -The readings ranged from 100 - 594. -There were two readings in the memory on 3/31, one reading of 255 at 9:14 pm and one reading of 181 at 9:16 p.m.. -There were two readings in the memory on 3/24, one reading of 158 at 9:17 pm and one reading of 173 at 9:32 p.m. -There were no readings in the memory for 3/25 - 3/27.	C 932		

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C 932	Continued From page 21 -There were two readings in the memory on 6/24, one reading of 212 at 4:57 pm and one reading of 128 at 5:07 p.m. -There were two readings in the memory on 6/17, one reading of 289 at 5:14 pm and one reading of 128 at 5:23 p.m. -There were two readings in the memory on 6/12, one reading of 192 at 4:40 pm and one reading of 182 at 4:42 p.m. -Ten of the FSBS readings in the memory did not match Resident #1's readings on the FSBS log. Review of Resident #1's June 2018 FSBS log revealed: -The resident's FSBS was checked daily from 6/1/18 - 6/11/18 for a total of eleven readings. -The FSBS on the log ranged from 140 - 198. -There were 4 documented FSBS readings on the FSBS log from 6/1/18 - 6/11/18 that were not in the memory of Resident #1's glucometer. -For example, the resident's FSBS was documented as 184 on 6/2/18 but there was no reading of 184 in the glucometer. -For example, the resident's FSBS was documented as 164 on 6/6/18 but there was no reading of 164 in the glucometer. Review of Resident #1's May 2018 FSBS log revealed: -The residents FSBS was checked daily from 5/1/18 - 5/30/18 for a total of 30 readings. -The FSBS on the log ranged from 100 - 358. -There were 15 documented FSBS readings on the FSBS log from 5/1/18 - 5/30/18 that were not in the memory of Resident #1's glucometer. -For example, the residents FSBS was documented as 190 on 5/1/18 but there was no reading of 190 in the glucometer. -For example, the residents FSBS was documented as 198 on 5/3/18 but there was no	C 932		

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C 932	Continued From page 22 reading of 198 in the glucometer. Interview with Resident #1 on 6/11/18 at 2:10 p.m. revealed: -He received FSBS checks about 2 - 3 times a week. -He did not know where the meter was stored. -He did not know if the meter was used for any other resident. Refer to the interview with the live-in personal care aide (PCA) on 6/11/2018 at 2:35 p.m. Refer to the interview with a second live-in PCA on 6/11/2018 at 3:05 p.m. Interview with the supervisor in charge (SIC) on 06/11/2018 at 3:53 p.m. Refer to the interview with Administrator on 6/12/2018 at 4:25 p.m. 2. Review of Resident #3's current FL-2 dated 1/29/18 revealed: -Diagnoses included dementia, renal failure, history of cerebral vascular accident, pace maker, and history of alcohol abuse. -There was an order to check finger stick blood sugar (FSBS) three times a week. Review of the memory data for a glucometer identified by two live-in personal care aides (PCAs) as Resident #3's (Brand B) glucometer on 6/11/18 at 3:50 p.m. revealed: -The date and time on the glucometer were set to the current date and time. -There were 19 readings in the memory data of the glucometer from 05/02/2018 - 6/11/2018. -The first three readings in the memory data were	C 932		

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C 932	Continued From page 23 for the month of June 2018 (06/09/2018 -06/11/2018). -There were no readings in the memory for 06/01/2018, 06/04/2018, 06/06/2018 and 06/07/2018. -The next sixteen readings in the memory data were for the month of May 2018 (05/02/2018-05/30/2018). -The readings ranged from 87 - 207. -There were two readings in the memory on 05/13/2018, one reading of 192 at 7:27 a.m. and one reading of 170 at 7:29 a.m. -There were no readings in the memory for 05/04/2018, 05/11/2018, 05/16/2018, 05/18/2018 and 05/25/2018. -There was a reading in the memory on 05/23/2018 of 104 that did not match the documented reading of 109 on Resident #3's FSBS log for 05/23/2018. Review of Resident #3's June 2018 FSBS log revealed: -The resident's FSBS was documented as checked seven times from 6/1/2018 - 6/11/2018. -The FSBS on the log ranged from 122 - 181. -There were 4 documented FSBS readings on the FSBS log from 6/01/2018 - 6/07/2018 that were not in the memory of Resident #3's glucometer. -For example, the resident's FSBS was documented as 158 on 06/01/2018 but this reading was not in the resident's (Brand B) glucometer, however, there was a reading of 158 in (Brand A) glucometer. -For example, the resident's FSBS was documented as 171 on 06/04/2018 but this reading was not in the resident's (Brand B) or in the (Brand A) glucometer. -For example, the resident's FSBS was documented as 168 on 06/06/2018 but this reading was not in the resident's (Brand B) or in	C 932		

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C 932	Continued From page 24	C 932		

the (Brand A) glucometer.
-For example, the resident's FSBS was documented as 181 on 06/07/2018 but this reading was not in the resident's (Brand B) glucometer, however there was a reading of 181 in (Brand A) glucometer.

Review of Resident #3's May 2018 FSBS log revealed:
-The residents FSBS was documented as checked nineteen times from 05/02/2018 - 05/30/2018.
-The FSBS on the log ranged from 87 - 289.
-There were seven documented FSBS readings on the FSBS log from 05/02/2018 - 5/30/18 that were not in the memory of Resident #3's glucometer.
-For example, the residents FSBS was documented as 147 on 05/04/2018 but this reading was not in the resident's (Brand B) glucometer , however, there was a reading of 147 in the (Brand A) glucometer.
-For example, the residents FSBS was documented as 162 on 05/11/2018 but this reading was not in the resident's (Brand B) or the (Brand A) glucometer.
-For example, the resident's FSBS was documented as 172 on 05/13/2018, but this reading was not in the resident's (Brand B) glucometer. (Brand B) glucometer did have one reading of 192 at 7:27 a.m. and one reading of 170 at 7:29 a.m.
-For example, the residents FSBS was documented as 118 on 05/16/2018 but this reading was not in the resident's (Brand B) glucometer or the (Brand A) glucometer.
-For example, the residents FSBS was documented as 289 on 05/18/2018 but this reading was not in the resident's (Brand B) glucometer , however, there was a reading of 289

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C 932	Continued From page 25 in the (Brand A) glucometer. -For example, the resident's FSBS was documented as 109 on 05/23/2018 but there was a reading of 104 in the resident's (Brand B) glucometer. -For example, the resident's FSBS was documented as 128 on 05/25/2018 but this reading was not in the resident's (Brand B) glucometer, however, there was a reading of 128 in the (Brand A) glucometer. Telephone interview with Resident #3 on 06/12/2018 at 11:23 a.m. revealed: -He received FSBS checks about 2 - 3 times a week. -He did not know where the meter was stored. -The same glucometer was used to take his FSBS and another resident's FSBS. Refer to the interview with the live-in personal care aide (PCA) on 6/11/2018 at 2:35 p.m. Refer to the interview with a second live-in PCA on 6/11/2018 at 3:05 p.m. Interview with the supervisor in charge (SIC) on 06/11/2018 at 3:53 p.m. Refer to the interview with Administrator on 6/12/2018 at 4:25 p.m. _____ Interview with a live-in personal care aide (PCA) on 6/11/18 at 2:35 p.m. revealed: -There were two residents who had orders for FSBS checks. -FSBS checks were completed for each resident as ordered. -Each resident had their own glucometer. -The glucometers were not labeled with the resident name.	C 932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 06/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

(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
C 932	Continued From page 26 -She knew which glucometer belonged to each resident because meters were shaped differently and were different brands. -She did not share glucometers between the two residents. -She did not know why some readings in the memory data did not match the readings on the FSBS log. Interview with a second live-in personal care aide (PCA) on 6/11/18 at 3:05 p.m. revealed: -There were two residents who had orders for FSBS checks. -Each resident had their own glucometer. -The glucometers were not labeled with resident name. -At one time there was a label with resident name inside the storage case. -The label had been missing for about 2 weeks. -He knew which meter belonged to each resident because meters were different brands. -He had never used the same glucometer on more than one resident. -Glucometers were not cleaned before or after use. -The Supervisor was responsible for reviewing blood sugar logs and she did this daily. -He did not know if Supervisor reviewed memory data in the glucometer. -He did not know why some readings in the memory data did not match the readings on the FSBS log. Interview with the supervisor in charge (SIC) on 06/11/2018 at 3:53 p.m. revealed: -She reviewed the residents' FSBS log but not the memory data in the glucometers. -She was not sure why the residents' FSBS results were not in their glucometers. -Staff did not have any other glucometers that	C 932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 06/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
C 932	Continued From page 27 could be used and the two residents in the facility had their own glucometers. Interview with the Administrator on 6/12/18 at 4:25 p.m. revealed: -She expected the PCA to check residents' FSBS as ordered by the physician. -Each resident had their own glucometers and the PCAs should not share glucometers between the residents. -FSBS should be recorded accurately on the log. -Glucometers should be cleaned with alcohol between each use. -Staff were trained during the annual infection control training that glucometers were not to be shared. -This had been reinforced to staff randomly throughout the year (no specific dates provided). -She had not checked the memory data of either glucometer. -Glucometers were labeled with each resident name at one time. -She had not checked the labels recently and labels could have worn off over time. -She notified the PCP on 6/12/18 that it appeared the glucometers had been shared between residents. -She was waiting on the PCP to write an order so that glucometers for Resident #1 and Resident #3 could be replaced. The facility failed to assure glucometers were not being shared by more than one resident resulting in possible exposure of blood borne pathogens by the sharing of glucometers which was detrimental to the health, welfare, and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/11/2018	C 932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 06/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

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C 932	Continued From page 28 and addendum 06/12/2018 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 27, 2018.	C 932		