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	HAL023046	A. BUILDING: _____ B. WING _____	R 01/25/2019

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SHELBY MANOR	1176 WYKE ROAD SHELBY, NC 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 01/24/19 and 01/25/19.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, reviews and interviews the facility failed to assure the facility was maintained in a clean and orderly manner, free of all obstructions and hazards related to the improper storage of resident care items in both of the bathroom spa areas and improper storage of items on the top rack in the dry food storage room, impeding the fire sprinklers. The findings are: 1. Observations during the initial tour on 01/24/19 from 9:00am-11:00am revealed: -At 9:33am the Spa near room #50 with walkers and resident supplies in several boxes stored in the room. -At 10:00am the dry food storage room had boxes stored on the top shelf up to the ceiling impeding the sprinklers.	D 079		

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D 079	Continued From page 1 -At 10:30am the spa near room #24 with walkers, wheelchairs and resident supplies stored in the room. Review of the Health Department dated 07/16/18 revealed: -A 0.5 demerit was deducted for items stored in the spa room such as boxes of patient care items. -A 0.5 demerit was deducted for items store on the floor in the spa room. Interview with the cook on 01/24/19 at 10:12am revealed: -There was not enough store area for all of the food and supplies. -She did not know about storing supplies on the top shelf covering up the sprinklers. -There was nowhere else to store the supplies for the kitchen available. Interview with the Dietary Manager (DM) on 01/24/19 at 10:15am revealed: -There was barely enough storage for all of the supplies so she stacked boxes on the top shelf. -she knew she needed to keep supplies off of the floor. -She did not know boxes were not to be stored on the top shelf causing the sprinklers to be covered up. -She did not have a policy for storage items near sprinklers. Interview with the Maintenance Director (MD) on 01/24/19 at 10:20am revealed the fire safety rules prevented storage of items within 18" of the ceiling. Interview with the Resident Care Coordinator (RCC) on 01/24/19 at 1:30pm revealed:	D 079		

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D 079	Continued From page 2 -There were not supposed to be anything stored on the top shelves in the dry storage room because of fire safety regulations. -The spas were not to be used as a storage area. Attempted interview with the Administrator on 01/25/19 at 2:49pm was unsuccessful.	D 079		
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, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 2 of 5 sampled residents (Resident #3 and #5) with physician orders for a chopped meat diet. The findings are: 1. Review of Resident #5's current FL2 dated 06/12/18 revealed diagnoses included chronic obstructive pulmonary disease, hypertension,	D 310		

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shortness of breath, congestive heart failure and cardiomyopathy.

Review of Resident #5's physician's diet order revealed an order dated 11/15/18 for a no added table salt and chopped meat diet.

Review of the therapeutic diet list posted in the kitchen on 01/11/19 revealed Resident #5 was to be served a chopped meat diet with no added table salt.

Review of the therapeutic diet menu for lunch on 01/24/19 revealed residents on a chopped meat diet were to be served chopped country fried steak, creamed potatoes with gravy, green beans, biscuit, beverage choice, and banana pudding.

Observation of lunch meal on 01/24/19 at 11:20pm revealed:
-Resident #5 was served country fried steak cut into (4) 1"x2" pieces, creamed potatoes with gravy, green beans, biscuit, beverage choice, and banana pudding.
-Resident #5 was having difficulty chewing the 1"x2" piece of country fried steak and spit it out.
-After asking the DM about the piece sizes of the meat the DM removed the meal from Resident #5 and cut the country fried steak into smaller ¼" pieces.
-Resident #5 was able to eat 50% of her meal without difficulties.

Observation of the kitchen on 01/24/19 at 11:20am revealed:
-The Dietary Manager (DM) used a fork to cut Resident #5's meat into 4- 1"x2" pieces.
-The DM prepared Resident #5's plate for lunch.

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Interview with the DM on 11:20am revealed:
-She knew Resident #5's diet was listed as being chopped meats with no added table salt on the therapeutic diet list.
-A chopped diet was to be cut up with a fork into "large pieces".
-She did not know the chopped meats were to be cut up into small pieces about ¼".
-She and the cook was responsible for preparing all meals.
-She completed online training and the state food service training when she was first hired.
-She received training from the contracted food service company regarding the menus.

Interview with Resident #5's Primary Care Provider (PCP) on 01/25/19 at 1:00pm revealed:
-Resident #5 was ordered a chopped meat diet.
-He ordered the chopped meat diet with nectar as a precaution because of Resident #3 was unable to hold her neck up.
-Resident #5 also had a hard time chewing up meat and swallowing because her neck could not stay at a neutral position during eating.
-He considered it detrimental for Resident #5 because she could choke on large pieces of meat which could lead to aspiration.
-He expected the facility staff to provide the food as ordered.

Telephone interview with Resident #5's family member on 01/25/19 at 1:08pm revealed:
-Resident #5 was on a chopped meat diet because of her difficulty chewing and swallowing.
-Resident #5 had false teeth which made it even harder to chew up large pieces of meat.
-Resident #5 choked before about a year ago because she can't hold her head up straight while she eats.
-He expected the facility staff to serve the diet as

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ordered.

Interview with the Registered Dietician (RD) on 01/25/19 at 1:30pm was unsuccessful.

Interview with Resident #5 on 01/25/19 at 2:00pm revealed:
-It was hard for her to chew her food if it was not cut up into small pieces.
-It was hard for her swallow her food because she could not hold her head up straight.

Refer to interview with the cook on 01/25/19 at 1:50pm revealed:

Interview with the Administrator on 01/25/19 at 2:49pm was unsuccessful.

Refer to interview with the RCC on 01/25/19 at 2:49pm revealed:

2. Review of Resident #3's current FL2 dated 01/08/19 revealed diagnoses included cerebral vascular accident (CVA), dysphasia, diabetes, and pelvis fracture.

Review of Resident #3's physician's diet order revealed an order dated 10/03/18 for a chopped meat diet.

Review of the therapeutic diet list posted in the kitchen on 01/11/19 revealed Resident #3 was to be served a chopped meat diet.

Review of the therapeutic diet menu for lunch on 01/24/19 revealed residents on a chopped meat diet were to be served chopped country fried steak, creamed potatoes with gravy, green beans, biscuit, beverage choice, and banana

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pudding.

Observation of lunch meal on 01/24/19 at 12:30pm revealed:
-Resident #3 was served country fried steak uncut, creamed potatoes with gravy, green beans, biscuit, beverage choice, and banana pudding.
-Resident #3 picked up the whole, uncut piece of country fried steak with her fingers and began to bit pieces of it off.
-After asking the DM about the diet for Resident #3, the DM removed the meal from Resident #3 and cut the country fried steak into smaller ¼" pieces.
-Resident #3 was able to eat 100% of her meal without difficulties.

Observation of the kitchen on 01/24/19 at 12:30pm revealed:
-The DM served a regular diet to Resident #3.
-The DM prepared Resident #6's plate for lunch.

Interview with the DM on 11:20am revealed:
-She knew Resident #3's diet was listed as being chopped meats on the therapeutic diet list.
-A chopped diet was to be cut up with a fork into "large pieces".
-She did not know the chopped meats were to be cut up into small pieces about ¼".
-She and the cook was responsible for preparing all meals.
-She completed online training and the state food service training when she was first hired.
-She received training from the contracted food service company regarding the menus.

Interview with Resident #3's Primary Care Provider (PCP) on 01/25/19 at 4:14pm revealed:
-He saw Resident #3 last on 01/24/19 and

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01/20/19.
-His notes revealed an order for Resident #3 to continue the chopped meat diet because of her history of a stroke and dysphagia after a recent hospitalization for a broken pelvis.
-He considered it detrimental to Resident #3 because not receiving the correct chopped meat diet could lead to a choking episode with possible aspiration.
-He expected the facility staff to provide the food as ordered.

Interview with the Registered Dietician (RD) on 01/25/19 at 1:30pm was unsuccessful.

Interview with Resident #3 on 01/25/19 at 2:10pm revealed:
-She had a stroke a few months ago.
-It was hard for her to swallow meats if she did not chew it up real good so when the physician ordered a chopped meat diet then it was easier for her to chew up the meat and swallow it without difficulty.
-The physician told her taking smaller bites would make it easier to chew up her food.

Interview with the Administrator on 01/25/19 at 2:49pm was unsuccessful.

Refer to interview with the cook on 01/25/19 at 1:50pm.

Refer to interview with the RCC on 01/25/19 at 2:49pm.

Interview with the cook on 01/25/19 at 1:50pm revealed:
-She and the DM prepares the diets as ordered by the physician.
-The DM or the Resident Care Coordinator (RCC)

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was responsible for posting the therapeutic diets on a flow sheet in the kitchen.
-She was trained how to prepare all therapeutic meals by the last cook when she was hired 3 years ago.
-A chopped meat diet was considered to be cut into ½" pieces.
-There was not any reference materials in the kitchen to clarify the size of the pieces of meat for a chopped diet.
The DM checked her meal preparation on all prepared therapeutic diets.

Interview with the RCC on 01/25/19 at 2:49pm revealed:
-She expected the cooks to refer to the therapeutic spreadsheet and recipe when preparing meals.
-The DM was responsible for preparing all diets according to the orders.
-She expected staff to refer to the therapeutic diet spreadsheet and recipes when preparing meals, as diets were ordered by the physicians.

The facility failed to assure Residents #3 and #5 were served diets as ordered by the physician. The facility's failure resulted in increased risk for Resident (#3) to choke on food who had a diagnosis of dysphagia and an increased risk of resident (#5) to choke on food because of the inability to hold her head up while she ate, which was detrimental to the 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 January 24/2019 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 10,

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D 310	Continued From page 9 2019.	D 310		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to infection prevention and serving therapeutic diets as ordered by a physician. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to implement an infection control policy consistent with the Centers for Disease Control and Prevention guidelines to ensure proper infection control procedures for the use of glucometers for 2 of 20 (Residents #2 and #7) diabetic residents with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. [Refer to Tag 932 G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (Type B Violation)]. 2. Based on observations, record reviews and	D912		

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D912	Continued From page 10 interviews, the facility failed to assure therapeutic diets were served as ordered for 2 of 5 sampled residents (Resident #3 and #5) with physician orders for a chopped meat diet. [Refer to Tag D0310, 10A NCAC 13F .0904 (e)(4) Therapeutic Diets. (Type B Violation)].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the	D932		

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D932	Continued From page 11 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 reviews, the facility failed to implement an infection control policy consistent with the Centers for Disease Control and Prevention guidelines to ensure proper infection control procedures for the use of glucometers for 2 of 20 (Residents #2 and #7) diabetic residents with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. The findings are: Observation of the blood sugar monitoring equipment on medication cart #2 on 01/24/19 at 11:16am revealed:	D932		

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D932	Continued From page 12 -There were five clear plastic containers labeled on the outside with five different resident's names. -Each plastic container contained a Brand A glucometer inside a black zippered pouch, multiple single use lancing devices, and reagent strips for use with a Brand A glucometer. -The plastic container labeled with Resident #2's name contained a black zippered pouch that was labeled with Resident #7's name. -Inside the black zippered pouch labeled with Resident #7's name, the Brand A glucometer was not labeled with a resident's name. -The plastic container labeled with Resident #7's name contained an unlabeled black zippered pouch with an unlabeled Brand A glucometer inside. Interview with the medication aide (MA) on 01/24/19 at 11:20am and 11:46am revealed: -She thought the unlabeled black zippered pouch belonged to Resident #2, even though it had been stored in plastic container labeled with Resident #7's name. -She did not know why Resident #7's pouch and glucometer were stored in Resident #2's plastic container. -She did not know if the unlabeled glucometer was "used on somebody else." -All the blood glucose monitoring supplies were "supposed to be labeled." -She was not sure if Resident #7's glucometer had been "used on somebody else." -She had worked the day before and "yesterday the meters weren't stored that way. Maybe they got them put in the wrong containers." -She was going to go to the Resident Care Coordinator (RCC) and see if the RCC had two new replacement glucometers for both of the affected residents.	D932		

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D932	Continued From page 13 -There were "usually" two new glucometers kept in the Medication Room storage closet. Observation of the RCC on 01/24/19 at 11:26am revealed the RCC removed a new Brand A glucometer from the Medication Room storage closet and labeled the glucometer and zippered pouch with Resident #2's name. Interview with the RCC on 01/24/19 at 11:27am revealed: -There was only one new glucometer available in the building which had just been assigned to Resident #2. -She would immediately order another new glucometer from the pharmacy for Resident #7, so they would have a new glucometer in the building in time to perform Resident #7's afternoon FSBS check. Review of the owner's manual (page #7) for Brand A glucometer revealed "These devices are intended to be used for patient self-monitoring and 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." Review of the CDC (Center for Disease Control and Prevention) guidelines for infection control revealed: -Blood glucose monitoring devices (glucometers) should not be shared between residents. -If the glucometer was 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.	D932		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	Continued From page 14 Interview with a second MA on 01/24/19 at 4:15pm revealed: -She had been trained to use resident specific equipment when performing FSBS checks. -She had never experienced any issues with resident glucometers not working or not having the proper supplies to be able to safely perform FSBS checks. Interview with a third MA on 01/24/19 at 4:45pm revealed: -She always made sure she had the "right resident and right machine" when she performed FSBS checks. -She had been trained to always use resident specific equipment when performing FSBS checks. -"I worked that hall and I didn't notice an unlabeled meter and pouch or any resident equipment in another resident's plastic storage box." Interview with the RCC on 01/25/19 at 4:09pm revealed: -Each shift was responsible for performing FSBS checks. -She felt like some of the values not matching between the glucometer history and the values documented on the eMARs could be caused by the glucometers "cutting off" before the MAs could get back to the cart and the MAs "may be guessing" at the result to record in the eMAR. -The facility policy was all of the glucometers and supplies to perform FSBS checks were to be labeled with the correct resident name and stored in a resident specific plastic container. -This helped to ensure every resident got the supplies that had been provided to them through their insurance. -The MA's had been trained to check each time	D932		

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	HAL023046	A. BUILDING: _____ B. WING _____	R 01/25/2019

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D932	Continued From page 15	D932		

they performed a FSBS check to make sure they had the "correct meter to resident."
-All the staff had training on the Brand A glucometers which had taught the staff how to set the dates and times on the Brand A glucometers.
-"They know they are supposed to use resident specific equipment. That's why everything is well labeled."
-There was always at least one new glucometer on hand in the facility at all times.
-Batteries to fit the Brand A glucometers were available to all staff who performed FSBS checks.

Telephone interview with the contracted licensed health professional support (LHPS) Nurse on 01/25/19 at 4:20pm revealed:
-The facility staff had been taught to get a new glucometer for each new admission with orders for FSBS checks.
-She had taught staff to keep the glucometers stored separately.
-She had taught them to "never share" glucometers.
-The glucometer, storage pouch, and the container they go in should be labeled so "there should be no mix up."
-She had trained the staff to do one FSBS check at a time and only to have one resident's supply box open at one time.
-She had taught the staff to "never cut corners" when performing resident care.
-The facility staff received infection control training annually.

1. Review of Resident #7's current FL2 dated 01/17/19 revealed:
-The diagnoses included diabetes mellitus.
-There was a physician's order for fingerstick blood sugar (FSBS) checks two times a day scheduled at 8:00am and 4:00pm.

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D932	Continued From page 16 Review of Resident #7's glucometer history revealed: -When the glucometer was powered on the date was 01/24/19 at 12:49pm, the glucometer date was 08/03 with no year indicated and the time was 8:13pm. -FSBS values recorded in the glucometer's history compared to values documented on Resident #7's electronic Medication Administration Record (eMAR) dated 01/19/19 to 01/24/19 were inconsistent in sequential order. -The most recent FSBS recorded in the glucometer history position #1 dated 08/03 at 2:18pm was 106. The result documented on the eMAR on 01/24/19 at 8:00am was 103. -The FSBS recorded in the glucometer history position #2 dated 08/03 at 12:12pm was 252. The result documented on the eMAR on 01/23/19 at 4:00pm was 135. -The FSBS recorded in the glucometer history position #3 dated 08/02 at 6:40pm was 110. The result documented on the eMAR on 01/23/19 at 8:00am was 234. -The FSBS recorded in the glucometer history position #4 dated 08/02 at 2:22pm was 99. There was no result documented on the eMAR on 01/22/19 at 4:00pm. -The FSBS recorded in the glucometer history position #5 dated 08/01 at 2:51pm was 131. The result was consistent with the result documented on the eMAR on 01/22/19 at 8:00am. -The FSBS recorded in the glucometer history position #6 dated 08/01 at 12:20pm was 119. The result was consistent with the result documented on the eMAR on 01/21/19 at 4:00pm. -The FSBS recorded in the glucometer history position #7 dated 07/30 at 11:44pm was 180. The result documented on the eMAR on 01/21/19	D932		

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D932	Continued From page 17 at 8:00am was 123. -The FSBS recorded in the glucometer history position #8 dated 07/30 at 2:32pm was 152. The result documented on the eMAR on 01/20/19 at 4:00pm was 180. -The FSBS recorded in the glucometer history position #9 dated 07/29 at 11:35pm was 104. The result documented on the eMAR on 01/20/19 at 8:00am was 152. -The FSBS recorded in the glucometer history position #10 dated 07/29 at 2:42pm was 97. The result documented on the eMAR on 01/19/19 at 4:00pm was 104. -The FSBS recorded in the glucometer history position #11 dated 07/28 at 11:55pm was 127. The result documented on the eMAR on 01/19/19 at 8:00am was 97. Review of Resident #7's January 2019 eMAR revealed: -There was an entry to check FSBS two times daily at 8:00am and 4:00pm. -FSBS results were documented daily at 8:00am with a FSBS range from 97 to 234. -FSBS results were documented daily at 4:00pm with a FSBS range from 104 to 180. Interview with Resident #7 on 01/25/19 at 4:40pm revealed: -She received FSBS checks first thing in the morning before breakfast and in the afternoon. -She did not really pay attention to what type of equipment staff used to check her blood sugar. -The staff always told her the result of her blood sugar check before giving her a dose of insulin. 2. Review of Resident #2's current FL2 dated 08/25/18 revealed the diagnoses included diabetes mellitus.	D932		

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D932	Continued From page 18 Review of Resident #2's physician order dated 11/07/18 revealed FSBS checks three times a day before meals scheduled at 8:00am, 12:00pm and 5:00pm. Review of the unlabeled glucometer history revealed: -When the glucometer was powered on the date was 01/24/19 at 12:52pm, the glucometer date was 01/24 with no year indicated and the time was 1:01am. -FSBS values recorded in the glucometer's history compared to values documented on Resident #2's electronic Medication Administration Record (eMAR) dated 01/19/19 to 01/24/19 were inconsistent in sequential order. -The most recent FSBS recorded in the glucometer history position #1 dated 01/23 at 6:46pm was 103. The result documented on the eMAR on 01/24/19 at 8:00am was 106. -The FSBS recorded in the glucometer history position #2 dated 01/23 at 4:36pm was 135. The result documented on the eMAR on 01/23/19 at 5:00pm was 252. -The FSBS recorded in the glucometer history position #3 dated 01/22 at 9:01pm was 234. The result documented on the eMAR on 01/23/19 at 12:00pm was 110. -The FSBS recorded in the glucometer history position #4 dated 01/22 at 5:37am was 130. The result documented on the eMAR on 01/23/19 at 8:00am was 99. -The FSBS recorded in the glucometer history position #5 dated 01/21 at 11:25pm was 164. The result documented on the eMAR on 01/22/19 at 5:00pm was 130. -The FSBS recorded in the glucometer history position #6 dated 01/21 at 8:24pm was 185. The result documented on the eMAR on 01/22/19 at 12:00pm was 164.	D932		

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D932	Continued From page 19 -The FSBS recorded in the glucometer history position #7 dated 01/21 at 5:21am was 152. The result documented on the eMAR on 01/22/19 at 8:00am was 185. -The FSBS recorded in the glucometer history position #8 dated 01/20 at 11:20pm was 244. The result documented on the eMAR on 01/21/19 at 5:00pm was 152. -The FSBS recorded in the glucometer history position #9 dated 01/20 at 6:46pm was 167. The result documented on the eMAR on 01/21/19 at 12:00pm was 144. -The FSBS recorded in the glucometer history position #10 dated 01/20 at 4:40am was 144. The result documented on the eMAR on 01/21/19 at 8:00am was 156. -The FSBS recorded in the glucometer history position #11 dated 01/19 at 11:55pm was 145. The result documented on the eMAR on 01/20/19 at 5:00pm was 144. -The FSBS recorded in the glucometer history position #12 dated 01/19 at 8:29pm was 176. The result documented on the eMAR on 01/20/19 at 12:00pm was 145. -The FSBS recorded in the glucometer history position #13 dated 01/19 at 4:34am was 142. The result documented on the eMAR on 01/20/19 at 8:00am was 176. Review of Resident #2's January 2019 eMAR revealed: -There was an entry to check FSBS three times daily at 8:00am, 12:00pm and 5:00pm. -FSBS results were documented daily at 8:00am with a FSBS range from 84 to 253. -FSBS results were documented daily at 12:00pm with a FSBS range from 66 to 227. -FSBS results were documented daily at 5:00pm with a FSBS range from 97 to 252.	D932		

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D932	Continued From page 20 Interview with Resident #2 on 01/25/19 at 4:44pm revealed: -She received FSBS checks three times a day. -The staff always told her the result of her blood sugar check before giving her a dose of insulin. -She had no complaints. -"Everything's fine." The facility's failure to implement infection control procedures consistent with the federal Center for Disease Control guidelines placed two resident's (Resident #2 and #7) who received finger stick blood sugar checks at risk due to possible exposure to blood borne pathogen diseases. 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 01/24/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 11, 2019.	D932		