STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032001	A. BUILDING: _____ B. WING _____	R 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENO POINTE ASSISTED LIVING	5600 N ROXBORO ROAD DURHAM, NC 27712

(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 and complaint investigation on June 4-6, 2019.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 7 sampled residents (Resident #4) was tested for tuberculosis disease (TB) upon admission. The findings are: Review of Resident #4's current FL-2 dated 06/04/19 revealed diagnoses of chronic respiratory failure, chronic obstructive pulmonary disease, type II diabetes, and atrial fibulation. Review of Resident #4's Resident Register revealed an admission date of 11/06/13. Review of Resident #4's record revealed: -A TB skin test was placed on 12/15/13 with	D 234		

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D 234	Continued From page 1	D 234		

negative results.
-There was no documentation of a second TB skin test for the resident.

Interview with Resident #4 on 06/06/19 at 8:27am revealed:
-The resident had one TB skin test done upon admission to the facility.
-The resident was not told to have a second TB skin test for admission.
-No one offered to take the resident to get the second TB skin test.

Interview with the Resident Care Coordinator (RCC) on 06/06/19 at 12:06pm revealed:
-She did not know Resident #4's second TB skin test was missing from his record.
-Residents were to have 2 TB skin tests done upon admission to the facility.
-She did not know why the second TB skin test was not done for Resident #4.
-The RCC was responsible for assuring residents had TB skin testing done upon admission to the facility.
-She did an audit of residents' TB skin tests in January 2019.
- She missed seeing Resident #4 did not have a second TB test.

Interview with the Administrator on 06/06/19 at 2:30pm revealed:
-Residents were to have the first TB skin test done before admission to the facility and could have the second TB skin test after they were admitted to the facility.
-She did not know there was no documentation of a second TB skin test for Resident #4.
-She looked in the Resident's records and was unable to find TB skin test information.
-The RCC was responsible for assuring residents

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D 234	Continued From page 2 had TB skin test information in their records. -She would have the second TB skin testing done as soon as possible for Resident #4.	D 234		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure the Licensed Health Professional Support (LHPS) evaluation was	D 280		

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completed quarterly for 1 of 7 sampled residents (Resident #3) having daily finger stick blood sugar checks and used a walker and wheel chair for ambulation.

The findings are:

Review of Resident #3's current FL-2 dated 10/28/18 revealed diagnoses of dementia, dysphagia, muscle weakness, vitamin D deficiency, type II diabetes, delusions, altered mental status and an order for daily finger stick blood sugar checks.

Review of Resident #3's record revealed there were no completed LHPS reviews for the resident.

Review of Resident #3's care plan dated 04/09/19 revealed the resident's care plan LHPS tasks were for finger sticks and ambulatory assistive devices.

Observation of Resident #3's room on 06/04/19 at 10:06am revealed there was a wheelchair and walker in resident's room.

Observation of Resident #3's room on 06/06/19 at 3:40pm revealed was a wheelchair, walker and cane in resident's room.

Interview with the Resident Care Coordinator (RCC) on 6/04/19 at 4:48pm revealed she did not know the quarterly LHPS review was missing from Resident #3's record.

Interview with the Administrator on 06/05/19 at 3:58pm revealed:
-The RCC was responsible for assuring the LHPS was completed for all residents.

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D 280	Continued From page 4 -She had not checked the LHPS binder for outstanding LHPS reviews. Telephone Interview with the LHPS nurse on 6/05/19 at 4:16pm revealed: -She did not remember assessing the resident. -She would look in her records to determine if she had assessed the resident. Telephone interview with Resident #3's primary care physician on 06/06/19 at 3:40pm revealed: -Resident #3 had used a wheelchair since admission to the facility. -Resident received finger sticks blood sugar checks to monitor blood glucose. -The resident had LHPS tasks for ambulatory assistive devices and finger sticks blood sugar checks and required a LHPS nurse to do quarterly assessments and reviews. Second interview with the RCC on 05/06/19 at 8:56am and at 3:02pm revealed: -She was responsible for contacting the LHPS nurse to schedule new and quarterly LHPS reviews. -The LHPS nurse was responsible for completing new and quarterly LHPS reviews. -A resident census was submitted to the LHPS nurse who scheduled all LHPS appointments. -Resident #3 had tasks of using ambulatory assistive devices and finger sticks blood sugar for monitoring her blood glucose. -There was no documentation of LHPS tasks quarterly reviews in the resident's record. -The RCC and the Administrator were responsible for completing the record reviews monthly. -Resident #3's LHPS quarterly assessment was not received from the LHPS nurse. Interview with Resident #3 05/06/19 at 3:40pm	D 280		

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D 280	Continued From page 5 revealed: - Her first time residing at the facility she did not use any ambulation assistive devices. -Her second time residing at the facility she had surgery and could not walk without walker or cane. -The resident used both a walker and a wheelchair but was more dependent on using a wheelchair.	D 280		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination related to a build-up of a black substance in the ice machine, dirty floors under the deep fryer and in the walk-in refrigerator, a black and white build-up on the shelves and walls in the walk-in refrigerator, a yellow liquid on shelves in the dry storage pantry, a yellow sticky film on the oven, deep fryer, and can opener,and food items stored in the refrigerator and the dry pantry that were not dated or labeled. The findings are: Review of the local Environment Health sanitation report dated 05/20/19 revealed: -The food service area had been inspected on	D 282		

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D 282	Continued From page 6 05/20/19 and received a score of 96.5. -The inspection report indicated observation of a visible soil build up on the blade of the can opener, ready to eat foods and prepared foods that were not dated when opened and not dated or labeled when stored, and a box of single use foam containers were stored directly on the floor. Observation of the kitchen and kitchen storage areas on 06/05/19 at 8:23am revealed: -A kitchen cleaning assignment schedule was posted and initialed, but did not include dates and times of cleaning. -A cooking oil box container had leaked oil on the flour in the dry storage room. -The storage shelves in the dry storage room were stained with a thick yellow liquid stubance. -There were thrree different cereal bins that were not dated and labeled in the dry storage pantry. -The containers for corn meal, sugar and flour were not labeled by name and storage date; the three scoops used for the corn meal, sugar and flour had thick dried white and black food particles. -The container for the corn meal was broken and left exposure to airborne contamination. Observation of the walk-in refrigerator on 06/05/19 at 8:45am revealed: -There was a thick layer of dust and a grey build-up on the two covers for the fans in the walk-in refrigerator. -There was a white and black slimy film on four of the shelves in the walk-in refrigerator. -There was a black film on the walls, the plastic curtains and the door of the walk-in refrigerator. -There was a dried brown liquid, food debris, a white greasy film and a black build-up on the floor to the walk-in refrigerator. -There were opened tubs of prepared egg salad,	D 282		

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chicken salad, pimento cheese and a gallon of mayonnaise; there was no open date on the containers.
-There was a plastic bin that contained ham, turkey, American cheese and hardboiled eggs without dates.
-There was a plastic container of prepared sandwiches that were not dated and labeled.

Observation of walk-in freezer on 06/05/19 at 8:55 am revealed:
-The shelved racks were covered with white and black food particles .
-The floor covered with yellow, white, and black food particles.
-There was ice build up on various spots on the floor and the lower part of the door.

Observation of stove and deep fryer on 06/05/19 at 9:21am revealed:
-The oven had not been cleaned and had food debris on the oven's floor.
-The deep fryer was covered with thick yellow brownish film; the right side of the deep fryer was covered with a yellow brownish thicky film and food particles.
-There was a build up of oil and food particles on the floor between and underneath the deep fryer and stove.

Observation of the ice machine on 06/05/19 at 9:22am reveal:
-The ice machine had black and gray substance build up in the machine and inside of the door.
-The ice scoop was covered with blackish and white food particles.

Interview with the evening cook on 06/06/19 at 3:45 pm revealed:
-The second shift kitchen staff were responsible

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for sweeping the floors and wiping off equipment every night.
-The kitchen staff used a daily cleaning schedule that was posted in the kitchen and the kitchen staff initialed on the cleaning assignment after it was completed.
-All kitchen staff were responsible for deep cleaning; the kithchen manager (KM) assigned deep cleaning assignments as needed and all the kitchen equipment was deep cleaned at least two times a month.
-The shelves in the walk-in refrigerator were removed and taken outside to be cleaned when the weather was nicer and the floors and the walls in the walk-in refrigerator were deep cleaned when the shelves were taken out.
-The floors, walls and shelves were deep cleaned about a year ago; the walk-in refrigerator was not on a schedule for deep cleaning.
-She tried to deep clean the kitchen equipment when she had time in the afternoon between meals.
-She did not clean the ice machine and she did not know the last time the ice machine had been cleaned because the KM cleaned the ice machine when it needed.

Interview with the KM on 06/05/19 at 9:25am revealed:
-He assigned the cleaning daily and weekly cleaning tasks for the second shift cooks.
-The second shift cooks were responsible for cleaning and sanitizing the entire kitchen.
-The cleaning schedule listed the items that were cleaned daily and weekly.
-The oven was cleaned weekly; the oven hood was cleaned by a contract company.
-The deep fryer was cleaned weekly; the cooking oil was changed weekly.
-The floors underneath the oven and deep fryer

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D 282	Continued From page 9 were swept and mopped daily. -The shelving in the walk-in freezer had not been deep cleaned. -The tabletop can opener was not on the routine cleaning schedule. -The ice was removed from the machine and is steamed cleaned and sanitized weekly. Interview with the Administrator on 06/06/19 at 10:30am revealed: -The ice machine was cleaned "routinely" but she did not know the "frequency". -The kitchen cleaning schedule was posted. -She completed kitchen tours but had not documented dates and times of the tours.	D 282		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure all residents received a non-disposable place setting consisting of a beverage container and a knife, spoon, and a fork at each meal.	D 287		

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D 287	Continued From page 10 The findings are: Review of the resident census report dated 06/04/19 revealed there was a census of 108 residents. 1. Observation of the lunch meal service in the main dining room on 06/05/19 at 12:05 pm revealed: -There were carafes on a wheeled cart with disposable cups. -Residents were served ice tea in the disposable cups by the personal care aides. -Residents who were served coffee were using disposable spoons to stir coffee. Observation of the lunch meal service in the second dining room on 06/05/19 at 12:15 pm revealed: -Water was served in a clear non-disposable plastic cup to every resident and some of the residents were served their iced tea in a non-disposable plastic cup; some of the residents were served their iced tea in a large disposable cup. -The coffee served to the residents was served in a large disposable cup; none received a coffee mug. -Ten residents received beverages in disposable cups and four residents were served multiple beverages in disposable cups. Observation of the kitchen on 06/05/19 at 1:20 pm revealed: -There were 24 small red non-disposable plastic cups that were clean and on a shelf that had not been used at the lunch meal service. -There were 75 coffee mugs that were clean and, on a shelf, and had not been used for the lunch meal service.	D 287		

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D 287	Continued From page 11 Observation of the dinner meal service in the main dining room on 06/05/19 at 6:05 pm revealed: -Twenty-four residents were offered coffee in disposable cups by a personal care aide (PCA). -Twenty-four residents were served coffee in the disposable cups. Interview with a resident on 06/05/19 at 12:18pm revealed: -He did not request a disposable cup to be served with his meal. -At times he did request a disposable cup for his beverage so he could take it back to his room. Interview with a resident on 06/05/19 at 6:15 pm revealed: -She had not seen a coffee mug in six months and the residents were told the facility staff was ordering new ones. -She was served her coffee in a disposable cup. Interview with two residents on 06/06/19 at 4:30 am revealed: -They did not know why some residents received disposable cups to drink out of and why other residents did not. -They did not ask for a disposable cup to use; sometimes they just got them with their beverage. Interview with a fourth resident on 06/06/19 at 8:55 am revealed: -He took his cup to his room after breakfast, so he could drink his water from his water pitcher; the staff filled the water pitcher, but did not give the residents cups to drink the water with. -He got disposable cups at almost every meal and he did not ask for a disposable cup. -He had been getting disposable cups for a long	D 287		

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D 287	Continued From page 12 time. -He could not remember the last time he got a coffee mug. Interview with a PCA on 06/05/19 at 12:35 pm revealed: -The residents took the non-disposableplastic cups back to their rooms and did not bring them back, so the kitchen started to serve disposable cups for the residents that liked to take beverages back to their room. -Every resident was served their coffee in a disposable cup. Refere to interview with the kitchen manager (KM) on 06/06/19 at 10:10 am. Refere to interview with the Administrator on 06/06/19 at 10:45 am. 2. Observation of the lunch meal service in the main dining room on 06/05/19 at 12:05 pm revealed: -Fourty-eight residents only received forks to use as an eating utensil. -None of the residents received knives. Observation of the lunch meal service in the second dining room on 06/05/19 at 12:15 pm revealed: -Residents were served a chicken leg, baked beans, green beans, a dinner roll, sliced apples, water, iced tea and coffee. -None of the residents received knives; each resident received a non-disposable fork and a non-disposable spoon when they were served their plates. -No knives were offered by staff to residents during the meal and no resident requested any knives.	D 287		

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D 287	Continued From page 13 Observation of the kitchen on 06/05/19 at 1:20 pm revealed there was a bin with non-disposable knives sitting on a counter; the knives had not been used for the lunch meal service. Observation of the dinner meal service in the second dining room on 06/05/19 at 5:56pm revealed only non-disposable forks and non-disposable spoons were served with the meal; none of the residents received a knife. Observation of the kitchen on 06/06/19 at 12:27 pm revealed: -There became a shortage of non-disposable forks and non-disposable spoons for residents during the meal service. -The kitchen staff gave the residents that did not have forks or spoons disposable forks and disposable spoons eat their meal with. Interview with a resident on 06/05/19 at 6:15 pm revealed the facility ran out of non-disposable silverware and had been using disposable tableware for six months. Interview with two residents on 06/06/19 at 4:30 am revealed: -They only had a non-disposable spoon and a non-disposable fork for their meals but would like a knife to cut their food. -Sometimes the food was "tuff" and they needed a knife to cut the meat. -They used to get knives but do not get knives anymore; they did not know why they did not get knives. -They had not asked for knives. Interview with a fourth resident on 06/06/19 at 8:55 am revealed:	D 287		

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ENO POINTE ASSISTED LIVING	5600 N ROXBORO ROAD DURHAM, NC 27712

(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 287	Continued From page 14 -He never got a knife to use, but he could use a knife to eat with at some meals. -He never "bothered" to ask for a knife because the staff would "just say no". Interview with a dietary aide on 06/06/19 at 12:27pm revealed disposable eating utensils were used when the non-disposable eating utensils ran out. Interview with a PCA on 06/05/19 at 12:35 pm revealed: -The kitchen used to send non-disposable knives to the dining room, but they stopped because the residents would take the knives back to their rooms. -It had been a while since the kitchen stopped sending knives; the residents used to ask for knives, but they did not any more. Refere to interview with the kitchen manager (KM) on 06/06/19 at 10:10 am. Refere to interview with the Administrator on 06/06/19 at 10:45 am. _____ Interview with the KM on 06/06/19 at 10:10 am revealed: -The residents took the non-disposable knives and the non-disposable cups to their rooms and did not return them so there was not enough of the cups and knives to go around. -He did not know if any residents complained about the disposable cups; some of the residents asked for the disposable cups so they could take their beverages back to their rooms. -He counted the cups and mugs once a week and ordered more if he needed them. -He tried to keep 125 large cups on hand and 250 small cups on hand.	D 287		

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D 287	Continued From page 15 -He had ordered 15 large cups a week ago. -He did not have enough coffee mugs to serve coffee for breakfast, so he used the disposable cups. -He had ordered more coffee mugs that morning, 06/06/19, he ordered enough to serve every resident out of a coffee mug and to have extra. -He only provided the residents with knives when they needed a knife for "cuttable meats"; knives were always available on request. -He did not know residents were supposed to have a non-disposable place setting consisting of a fork, knife and a spoon and beverage containers. Interview with Administrator on 06/06/19 at 10:45am revealed disposable cups were used only for "to go" when requested by residents to take beverages out of the dining hall.	D 287		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were served nutritious and palatable meals. The findings are: 1. Review of the lunch menu for 06/05/19 revealed "Chef's choice" was listed for the entrée,	D 297		

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D 297	Continued From page 16 the starchy vegetable and the vegetable. and a wheat or white roll with seasonal fruit. Interview with the Kitchen Manager (KM) on 06/05/19 at 11:30 am revealed he had prepared BBQ chicken legs, baked beans, green beans, dinner rolls and fruit for the lunch meal. Observation of lunch meal service in the main dining hall on 06/05/19 at 11:52 am revealed: -The meal served was BBQ chicken legs, baked beans, green beans, dinner rolls and sliced apples. -One baked chicken leg was served with the meal. -One wheat dinner roll was served with the meal; some of the wheat rolls were served burned. Observation of the lunch meal service in the second dining room on 06/05/19 at 12:15 am revealed: -The residents were served barbecue chicken legs, baked beans, green beans, dinner roll, canned fruit, water, iced tea. -One BBQ chicken leg was served on each plate. -One wheat dinner roll was served on each plate; the rolls were dark brown on the sides and bottoms. Interview with a resident on 06/05/19 at 12:25 pm revealed: -She did not eat all of the barbecue chicken because it tasted burned and the barbecue sauce was used to just cover the flavor of burned chicken. -The green beans had no flavor and the roll was burned on the bottom. Interview with a second resident on 06/05/19 at 12:35pm in the second dining room revealed she	D 297		

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D 297	Continued From page 17 did not like the meal because the chicken leg was dried out and the green beans did not taste good. 2. Review of the menu for the lunch meal on 06/06/19 revealed beef tips with gravy, macaroni and cheese, broccoli, wheat roll and dessert cart were documented. Observation of the lunch meal service in the main dining room and the second dining room on 06/06/19 at 12:05pm revealed the residents were served beef tips with gravy, noodles, macaroni and cheese, broccoli, dinner roll, vanilla pudding or gelatin, water and iced tea. Interview with two residents on 06/04/19 at 10:25 am revealed : -The food served at the facility was not good; it tasted bad. -The food was overcooked or undercooked. Interview with a third resident on 06/04/19 at 10:50am revealed: -The vegetables and did not taste good, -The vegetables were hard, they were not cooked enough. Interview with a fourth resident on 06/06/19 at 12:21 pm revealed: -She was not able to eat the broccoli because it was too hard. -She was not able to eat the roll because it was burned on the bottom and the meat and macaroni and cheese were not like home cooking. -She ate some of the vanilla pudding, but she did not eat the rest of the meal. Interview with a fifth resident on 06/06/19 at 12:28 pm revealed: -She was not eating the broccoli because it was	D 297		

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not cooked, the beef tips had a bad flavor, and the roll was burned on the bottom.
-She was eating the vanilla pudding and drink her tea.

Interview with a sixth resident on 06/06/19 at 12:29 pm revealed the broccoli was too hard to chew.

Interview with three residents on 06/06/19 at 9:10 am revealed:
-The food was bad because the food never seemed to be cooked "right".
-Most of the time the dinner rolls were burned on the bottom.
-The food was awful.
-The food was usually "burnt"; the BBQ chicken legs at lunch the day before were burned and the rolls were burned on the bottom.

Interview with the Kitchen Manager on 06/04/19 at 12:47 pm and on 06/06/19 at 3:35pm revealed:
-He had not heard of complaints of overcooked or undercooked food, or about the burned dinner rolls from residents
-Overcooked or burned food was not served to residents and would be thrown out.
-The food was prepared in ovens with even heating temperatures.
-He tried to walk through the dining room before and after service to speak to residents; he did not get complaints about the food when he spoke to residents.

Interview with the evening cook on 06/06/19 at 3:45pm revealed:
-She did not overcook or undercook the food she prepared.
-If she burned food while cooking it she would throw it out.

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D 297	Continued From page 19 -She would not serve undercooked food. Interview with the Administrator on 06/06/19 at 4:20 pm revealed: -Residents had not complained to her about bad food. -She walked through one of dining rooms at least one time a day during a meal and she had not seen burned food. -She eats the food from the kitchen and thought it was good.	D 297		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 8 ounces of milk was served to the residents twice a day. The findings are: Observation of the dinner meal service in the main dining room on 06/05/19 at 6:01 pm revealed: -There were forty-eight residents who were not	D 299		

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D 299	Continued From page 20 served milk. -There were forty-eight residents who were not offered milk Review of the dinner meal menu for 06/05/19, Wednesday, revealed milk was listed as a beverage to be served to the residents. Review of the resident regular menu for the week of 06/09/19 revealed milk was on the menu to be served for breakfast and dinner meal services. Observation of the main dining room breakfast service on 06/06/19 at 8:35 am revealed only residents that were served cold cereal received milk. Observation of lunch meal service in the second dining room on 06/06/19 at 12:07 pm revealed milk was not served or offered to the residents who were present for lunch. Observation of the walk-in refrigerator on 06/05/19 at 9:18 am revealed twelve gallons of 2% milk was available to be served. Based on the resident census of 108 and the menu the facility required 13.5 gallons of milk each day. Review of delivery invoices from the contracted food supply company revealed: -Twenty gallons of 2% milk were delivered on 04/16/19, 04/23/19 and 04/30/2019. -Twenty gallons of 2% milk were delivered on 05/07/19, 05/14/19, and 05/21/19; twenty-four gallons of 2% milk were delivered on 05/28/19. -Twenty gallons of 2% milk were delivered on 06/04/19; no other milk was listed on the delivery invoices.	D 299		

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D 299	Continued From page 21 Interview with a resident from the main dining room on 06/05/19 at 6:15 pm revealed: -She liked milk and she did get milk at breakfast. -She would drink milk if it was given to her at meals. -Residents were able to get milk at lunch and dinner if they asked for milk. Interview with a resident from the second dining room on 06/05/19 at 6:15pm revealed: -Milk was not served or offered at the dinner meal; milk had never been served at the dinner meal. -He did not ask for milk to drink at dinner because he thought milk was not available, he did not see milk on the tables. -Breakfast was the only meal milk was offered and only in a small 4 ounce juice glass. Interview with a second resident from the second dining room on 06/05/19 at 6:20pm revealed: -He did not ask for milk at dinner, he did not see any milk served at dinner, it was not available. -He would drink a glass of milk if he were served the milk. Interview with a third resident from the second dining room on 06/05/19 at 6:23pm revealed: -He never received milk with his meals. -Milk was served to a couple of residents at breakfast, but only in the small juice glasses. -He would like to have milk with his meals, but was never asked or offered a glass of milk. Interview with a fourth resident from the second dining room on 06/05/19 at 6:25pm revealed: -No milk was served or offered at dinner. -She loved to drink milk' and she would drink it if	D 299		

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D 299	Continued From page 22 staff offered it. -She was hesitant to ask (for milk) since she did not see milk being served at the dinner meal. Interview with a fifth resident on 06/06/19 at 8:50 am revealed: -She was served milk in a small glass. -She had not asked for milk; she got milk "automatically" because the staff knew she liked milk. Interview with a sixth resident on 06/06/19 at 9:10 am revealed: -He requested milk with his cereal. -The only way to be served milk was to ask for cereal; no one asked him if he wanted milk to drink. Interview with a seventh resident on 06/04/19 at 11:35 am revealed milk was not served "all the time" and milk was served with cereal only at breakfast. Interview with a dietary aide on 06/05/19 at 6:20 pm revealed: -Residents must request milk at dinner. -She did not set the milk out with the other beverages to be served. Interview with the Kitchen Manager (KM) on 06/06/19 at 10:15am revealed: -Residents received milk based on their diets or "offered" to the residents who requested milk as a preference. -The staff offered milk in the dining room every day. -Milk was served at breakfast, but he was not sure about lunch and dinner. -He also used milk to cook with when the recipe called for milk.	D 299		

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D 299	Continued From page 23 -The kitchen served four to five gallons of milk a day to residents. -Milk was ordered and delivered once a week. Interview with the Supervisor in Charge (SIC) on 06/06/19 at 10:30 am revealed: -The personal care aides were trained during orientation to only pour coffee. -Milk was served with cold cereal at breakfast. -Residents were to request milk for lunch and dinner. -The kitchen staff had the responsibility for milk poured into the glasses and placed on the residents' trays at breakfast. -The personal care aides served milk only. -She knew milk was to be served twice a day. -Residents could always ask the staff for milk. Interview with Administrator on 06/06/19 at 10:45am revealed: -Milk was served at breakfast according to a residents' diet plan. -Milk was "offered" to the residents by request at lunch and dinner.	D 299		
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: Based on observations, record reviews, and interviews, the facility failed to assure 2 of 8 sampled residents (#1 and #8) with physician orders for mechanical soft with chopped meats	D 310		

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D 310	Continued From page 24	D 310		

diet and a pureed diet with honey thick liquids was served as ordered.

The findings are:

1. Review of Resident #1's current FL-2 dated 07/17/18 revealed:
-Diagnoses included diabetes mellitus type 2, hypertension, dental decay, proliferative diabetic retinopathy, hypotensive retinopathy, and congenital cognitive deficits.
-There was a diet order for mechanical soft with chopped meats, no added table salt (NATS).

Review of Resident #1's diet order form dated 10/16/18 revealed a diet order of consistent carbohydrates, mechanical soft with chopped meats.

Review of the lunch menu for 06/05/19 revealed "Chef's choice" was listed for the entrée, the starchy vegetable and the vegetable.
and a wheat or white roll with seasonal fruit.

Interview with the kitchen manager (KM) on 06/05/19 at 11:30 am revealed he had prepared BBQ chicken legs, baked beans, green beans, dinner rolls and sliced apples for the lunch meal.

Observation of the lunch meal service on 06/05/19 at 12:19 pm revealed:
-Resident #1 was served green beans, one whole barbecue chicken leg, baked beans, a roll, canned pears, water and iced tea.
-Resident #1 ate one-third of the chicken leg, one bite from the roll, one-half of the pears, and one-half of the green beans, one-half of the baked beans and drank half of the beverages.

Interview with Resident #1 on 06/05/19 at 12:25

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D 310	Continued From page 25 pm revealed: -She did not eat all of the barbecue chicken because it was burned and the barbecue sauce was used to just cover the burned chicken. -The green beans had no flavor and the roll was burned on the bottom. Interview with the day shift cook on 06/05/19 at 12:18 pm revealed: -She had not chopped her meats because Resident #1 told her not to chop the meats. -She had not asked Resident #1 if she wanted her barbecue chicken chopped or not she just assumed she did not want the chicken chopped. -She did not tell the medication aide about Resident #1's request to not have her meats chopped. Review of the menu for the lunch meal on 06/06/19 revealed beef tips with gravy, macaroni and cheese, broccoli, wheat roll and dessert cart were documented. Observation of the lunch meal service on 06/06/19 at 12:15 pm revealed: -Resident #1 was served broccoli, beef tips with gravy, noodles, macaroni and cheese, roll, vanilla pudding, iced tea, and water. -Resident #1 ate the vanilla pudding and drank half of the beverages. Second interview with Resident #1 on 06/06/19 at 12:21 pm revealed: -She was not able to eat the broccoli because it was too hard. -She was not able to eat the roll because it was burned on the bottom and the meat and macaroni and cheese were not good. -She ate some of the vanilla pudding, but she did not eat the rest of the meal.	D 310		

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D 310	Continued From page 26 Attempted telephone interview with Resident #1's physician on 06/05/19 at 1:20 pm was unsuccessful. Third interview with Resident #1 on 06/06/19 at 10:46 am revealed: -When she was first admitted, the meats were chopped. -She had a mechanical soft with chopped meats diet because she did not have any teeth except two teeth at the bottom front. -She could not chew meats especially when they were cooked hard and dry. -Now sometimes the meats served to her were chopped and sometimes the meats were not chopped. -Sometimes the dietary staff asked her if she would like her meats chopped and sometimes they did not ask her. -She did not want her meats chopped for one meal during the week of 05/26/19 to 06/01/19. -She was able to eat meats if they were served very tender or soft. 2. Review of Resident #8's current FL-2 dated 11/07/18 revealed: -Diagnoses included non-ST-elevation myocardial infarction, history of dementia, hypertension, spinal stenosis and bipolar. -There was an order for a pureed diet and honey thick liquids. Review of a diet order dated 12/12/18 revealed Resident #8 was on a pureed diet with honey thick liquids. Review of the therapeutic diet list posted in the kitchen on 06/05/19 at 8:45am revealed Resident #8 was on a pureed diet with honey thick liquids.	D 310		

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D 310	Continued From page 27 Review of the lunch menu for 06/05/19 revealed "Chef's choice" was listed for the entrée, the starchy vegetable and the vegetable. and a wheat or white roll with seasonal fruit. Interview with the Kitchen Manager (KM) on 06/05/19 at 11:30 am revealed he had prepared BBQ chicken legs, baked beans, green beans, dinner rolls and sliced apples for the lunch meal. Observation of the lunch meal service on 06/05/19 at 12:15 am revealed: -The meal served to Resident #8 was pureed pink meat, creamed corn, and two cups of apple sauce. -The pureed meat had a clear liquid that pooled in the bowl around the meat and in the center of the meat once Resident #8 began to eat. -The creamed corn did not appear to be pureed and was less than mashed potato consistency. -The creamed corn was runny and had a milky liquid pooled around the sides of the bowl. -Resident #8 fed himself and began to cough when he ate his meal. -The medication aide (MA) took Resident #8's plate away from him and left the dining room. -The MA returned with a second plate that had a pureed pink meat, creamed corn and two cups of apple sauce; there was no liquid around the food and the cream corn had been pureed to a mashed potato consistency. -Resident #8 consum Interview with the MA on 06/05/19 at 12:20 am revealed she took the plate back to the kitchen and the cook thickened the pureed food with food thickener; Resident #8 never chokes on his food it was the extra liquid in the plate.	D 310		

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D 310	Continued From page 28 Based on observations, interviews and record reviews it was determined Resident #8 was not interviewable. Interview with the KM on 06/06/19 at 12:35 pm revealed: -He had pureed smoked turkey and creamed corn for the pureed diet lunch menu on 06/05/19. -He was told by a dietitian how to make pureed food and the dietitian did not demonstrate how to prepare pureed foods. -The dietitian told him to make the food "like creamy mashed potatoes" for pureed diets; the dietitian did not watch him prepare any pureed items. -He understood the pureed food could not have excess liquid because residents on thickened liquids could choke; he had never had a problem with the consistency of the pureed food before yesterday; Interview with the Administrator on 06/06/19 at 4:15 pm revealed: -A dietitian had trained the KM on how to puree foods for the pureed diets. -She did not watch the dietitian conduct the training for the KM, so she did not know what the KM was shown to do and she did not know if the KM demonstrated how to prepare pureed food for the dietitian. -The KM had a list of resident diets in the kitchen and she knew the KM followed the diets; she had not heard of a problem with Resident #8 coughing or choking on his food.	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:	D912		

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D912	Continued From page 29 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 every resident had the right to receive care and services which are adequate, appropriate, and in compliance with state laws and rules related to the sharing of glucometers to obtain residents' finger stick blood sugars. The findings are: Based on observations, record reviews, and interviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for diabetic residents resulting in sharing glucometers between residents. [Refer to Tag D 932 G. S. 131D-4.4A(b) ACH Infection Prevention Requirements (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	D932		

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D932	Continued From page 30 (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the 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.	D932		

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D932	Continued From page 31	D932		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observation, record reviews, and interviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 2 of 3 sampled residents (#1 and #11) with diabetes, resulting in sharing glucometers between residents.

The findings are:

Review of the CDC 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 instruction. If the manufacturer does not list disinfecting information, then the glucometer should not be shared between residents.

Review of manufacturer's user guide for Brand A glucometer revealed:
-The glucometer was a single use glucometer (intended for self- testing only) and the glucometer should not be shared with other users.

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D932	Continued From page 32 -There were disinfection instructions as follows: cleanse once a week with a germicidal wipe. Review of Brand A glucometer #1's history revealed: -The glucometer was not in a case, did not belong to a resident and it was not labeled with a resident's name. -The glucometer was working without any error messages. -The glucometer readings were reviewed for a portion of March 2019 and April 2019. -There was a reading for 03/23/19 at 6:51 am of 120. -There was a reading for 03/23/19 at 12:28 pm of 75. -There was a reading for 03/23/19 at 4:22 pm of 168. -There was a reading for 03/23/19 at 4:27 pm of 208. -There was a reading for 03/23/19 at 4:29 pm of 179. -There was a reading for 03/23/19 at 4:31 pm of 159. -There was a reading for 03/23/19 at 4:35 pm of 188. -There was a reading for 03/25/19 at 7:23 am of 126. -There was a reading for 03/25/19 at 4:31 pm of 209. -There was a reading for 03/25/19 at 4:35 pm of 111. -There was a reading for 03/25/19 at 4:39 pm of 74. -There was a reading for 03/25/19 at 4:43 pm of 138. -There was a reading for 03/25/19 at 4:54 pm of 108. -There was a reading for 03/26/19 at 5:42 am of 99.	D932		

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D932	Continued From page 33 -There was a reading for 03/26/19 at 8:11 am of 118. -There was a reading for 03/26/19 at 10:32 am of 166. -There was a reading for 03/26/19 at 10:45 am of 176. -There was a reading for 03/26/19 at 10:47 am of 165. -There was a reading for 03/26/19 at 11:23 am of 145. -There was a reading for 04/07/19 at 5:43 am of 165. -There was a reading for 04/07/19 at 6:37 am of 127. -There was a reading for 04/07/19 at 7:01 am of 100. -There was a reading for 04/07/19 at 7:07 am of 129. -There was a reading for 04/07/19 at 7:40 am of 139. -There was a reading for 04/17/19 at 6:17 am of 124. -There was a reading for 04/17/19 at 7:57 am of 161. -There was a reading for 04/17/19 at 10:00 am of 110. -There was a reading for 04/17/19 at 10:09 am of 194. -There was a reading for 04/17/19 at 10:24 am of 244. -There was a reading for 04/18/19 at 6:32 am of 122. -There was a reading for 04/18/19 at 7:09 am of 93. -There was a reading for 04/18/19 at 7:11 am of 90. -There was a reading for 04/18/19 at 7:14 am of 163. -There was a reading for 04/18/19 at 4:32 pm of 225.	D932		

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D932	Continued From page 34 -There was a reading for 04/18/19 at 4:37 pm of 229. -There was a reading for 04/18/19 at 4:40 pm of 117. -There was a reading for 04/18/19 at 4:43 pm of 68. -There was a reading for 04/18/19 at 4:47 pm of 132. -There was a reading for 04/19/19 at 9:51 am of 147. -There was a reading for 04/19/19 at 10:24 am of 160. -There was a reading for 04/19/19 at 10:44 am of 245. -There was a reading for 04/19/19 at 4:32 pm of 271. -There was a reading for 04/19/19 at 4:35 pm of 156. -There was a reading for 04/19/19 at 4:37 pm of 105. -There was a reading for 04/19/19 at 4:39 pm of 296. -There was a reading for 04/19/19 at 4:48 pm of 107. Based on observations and record reviews there were two glucometer readings on Brand A glucometer #1 that was documented on Resident #1's April 2019 eMAR on 04/18/19 at 7:30 am of 90 and on 04/19/19 at 5:30 pm of 105. Review of Brand A glucometer #2's history revealed: -The glucometer was not in a case, did not belong to a resident and it was not labeled with a resident's name. -The glucometer was working without any error messages. -The glucometer readings were reviewed for a portion of March 2019, April 2019, and June	D932		

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D932	Continued From page 35 2019. -There was a reading for 03/27/19 at 7:21 am of 115. -There was a reading for 03/27/19 at 7:23 am of 146. -There was a reading for 03/27/19 at 7:26 am of 149. -There was a reading for 03/27/19 at 7:27 am of 130. -There was a reading for 03/27/19 at 10:00 am of 80. -There was a reading for 03/27/19 at 10:35 am of 98. -There was a reading for 03/27/19 at 11:01 am of 116. -There was a reading for 03/27/19 at 11:05 am of 134. -There was a reading for 03/27/19 at 11:10 am of 131. -There was a reading for 03/27/19 at 11:14 am of 65. -There was a reading for 03/28/19 at 5:15 pm of 158. -There was a reading for 03/28/19 at 5:35 pm of 238. -There was a reading for 04/04/19 at 6:08 am of 103. -There was a reading for 04/04/19 at 6:28 am of 147. -There was a reading for 04/04/19 at 6:32 am of 107. -There was a reading for 04/04/19 at 6:53 am of 76. -There was a reading for 04/04/19 at 6:54 am of 116. -There was a reading for 04/04/19 at 7:09 am of 81. -There was a reading for 04/04/19 at 7:33 am of 85. -There was a reading for 04/04/19 at 8:33 am of	D932		

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D932	Continued From page 36 167. -There was a reading for 04/04/19 at 10:54 am of 254. -There was a reading for 04/04/19 at 11:07 am of 187. -There was a reading for 04/04/19 at 11:10 am of 206. -There was a reading for 04/04/19 at 11:26 am of 118. -There was a reading for 04/06/19 at 11:27 am of 140. -There was a reading for 04/06/19 at 4:53 pm of 271. -There was a reading for 04/06/19 at 4:57 pm of 146. -There was a reading for 04/06/19 at 4:59 pm of 122. -There was a reading for 04/06/19 at 5:03 pm of 243. -There was a reading for 04/07/19 at 10:27 am of 122. -There was a reading for 04/11/19 at 5:12 am of 135. -There was a reading for 04/11/19 at 5:52 am of 125. -There was a reading for 04/11/19 at 5:54 am of 146. -There was a reading for 04/11/19 at 6:58 am of 163. -There was a reading for 04/11/19 at 7:35 am of 145. -There was a reading for 04/11/19 at 8:16 am of 80. -There was a reading for 04/11/19 at 10:38 am of 149. -There was a reading for 04/11/19 at 11:03 am of 154. -There was a reading for 04/11/19 at 11:26 am of 133. -There was a reading for 04/18/19 at 6:21 am of	D932		

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D932	Continued From page 37 89. -There was a reading for 04/18/19 at 11:09 am of 139. -There was a reading for 04/22/19 at 7:57 am of 114. -There was a reading for 04/22/19 at 11:22 am pf 89. -There was a glucometer reading for 04/23/19 at 7:18 am of 102. -There was a glucometer reading for 06/05/19 at 8:06 am of 194. Based on observations and record reviews there was one glucometer reading on Brand A glucometer #2 that was also documented on Resident #1's April 2019 eMAR on 04/04/19 at 7:30 am of 85. Based on observations and record reviews there was one glucometer reading on Brand A glucometer #2 that was also documented on Resident #11's June 2019 eMAR on 06/05/19 at 7:30 am of 194. Review of Brand A glucometer #3's history revealed: -The glucometer was not in a case, did not belong to a resident and it was not labeled with a resident's name. -The glucometer was working without any error messages. -The glucometer readings were reviewed for March 2019 and April 2019. -There was a reading for 03/26/19 at 6:37 am of 134. -There was a reading for 03/26/19 at 7:05 am of 115. -There was a reading for 03/26/19 at 7:13 am of 148. -There was a reading for 03/26/19 at 8:15 am of	D932		

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D932	Continued From page 38 73. -There was a reading for 03/26/19 at 10:46 am of 190. -There was a reading for 03/26/19 at 11:04 am of 65. -There was a reading for 03/26/19 at 11:11 am of 213. -There was a reading for 03/26/19 at 11:29 am. of 108. -There was a reading for 03/27/19 at 7:08 am of 175. -There was a reading for 03/27/19 at 7:16 am of 116. -There was a reading for 03/27/19 at 10:10 am of 115. -There was a reading for 03/27/19 at 10:31 am of 131. -There was a reading for 03/27/19 at 10:46 am of 107. -There was a reading for 03/28/19 at 6:19 am of 213. -There was a reading for 04/08/19 at 5:41 am of 135. -There was a reading for 04/09/19 at 5:21 am of 121. -There was a reading for 04/18/19 at 5:18 am of 114. -There was a reading for 04/19/19 at 5:07 am of 99. -There was a reading for 04/19/19 at 5:50 am of 148. -There was a reading for 04/19/19 at 5:52 am of 85. -There was a reading for 04/19/19 at 5:58 am of 171. -There was a reading for 04/19/19 at 6:06 am of 96. -There was a reading for 04/19/19 at 6:22 am of 112. -There was a reading for 04/19/19 at 6:54 am of	D932		

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D932	Continued From page 39 79. -There was a reading for 04/20/19 at 6:04 am of 105. -There was a reading for 04/20/19 at 6:06 am of 226. -There was a reading for 04/20/19 at 6:14 am of 96. -There was a reading for 04/20/19 at 6:19 am of 156. -There was a reading for 04/20/19 at 7:24 am of 74. -There was a reading for 04/20/19 at 10:44 am of 200. -There was a reading for 04/20/19 at 10:53 am of 242. -There was a reading for 04/20/19 at 10:56 am of 141. -There was a reading for 04/20/19 at 11:00 am of 156. -There was a reading for 04/21/19 at 5:51 am of 102. -There was a reading for 04/21/19 at 5:58 am of 101. -There was a reading for 04/21/19 at 6:02 am of 152. -There was a reading for 04/21/19 at 6:05 am of 93. -There was a reading for 04/21/19 at 6:10 am of 288. -There was a reading for 04/21/19 at 10:48 am of 153. -There was a reading for 04/21/19 at 10:53 am of 300. -There was a reading for 04/21/19 at 10:59 am of 134. -There was a reading for 04/21/19 at 11:01 am of 111. -There was a reading for 04/21/19 at 4:03 pm of 306. -There was a reading for 04/21/19 at 4:18 pm of	D932		

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D932	Continued From page 40 129, -There was a reading for 04/21/19 at 4:21 pm of 91. -There was a reading for 04/21/19 at 4:22 pm of 147. -There was a reading for 04/22/19 at 5:05 am of 180. -There was a reading for 04/25/19 at 6:06 am of 79. -There was a reading for 04/25/19 at 10:43 am of 76. Based on observations and record reviews there were four glucometer readings on Brand A glucometer #3 that were documented on Resident #1's April 2019 eMAR on 04/19/19 at 7:30 am of 79, 04/20/19 at 7:30 am of 74, 04/21/19 at 5:30 pm of 91, and 04/25/19 at 7:30 am of 79. Review of manufacturer's user guide for Brand B glucometer revealed: -The glucometer could be used for self-testing at home or professional clinical use, a multi-use meter. -The outer portion of the glucometer could be cleaned with a damp cloth and mild soap. -The glucometer strip port should be protected from getting wet. Telephone interview with a company representative for Brand B glucometer for 06/05/19 at 10:41 am revealed: -Brand B could be used as a single-use or multi-use glucometer, but the glucometer had to be sanitized in between residents. -Brand B glucometer should be sanitized with a germicidal wipe and care should be taken to not get the test strip port wet.	D932		

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D932	Continued From page 41 Interview with a resident for 06/06/19 at 4:45 pm revealed: -The staff always cleaned her finger off before pricking it and if they did not she reminded them to clean her finger. -She did not recall the staff cleaning her glucometer before using it for her blood glucose checks. -She thought she had her own glucometer. 1. Review of Resident #1's current FL-2 dated 07/17/18 revealed: -Diagnoses included diabetes type 2, hypertension, proliferative diabetes retinopathy. -There was an order for blood glucose checks twice daily before breakfast and dinner. Review of Resident #1's subsequent physician orders revealed there was an order dated 08/28/18 for blood glucose checks twice daily before breakfast and dinner, call physician if fingerstick greater than 450 or less than 60. Review of Resident #1's April 2019 electronic medication administration record (eMAR) revealed: -There was an entry for blood glucose checks twice a day before breakfast and before dinner call physician if fingerstick greater than 450 or less than 60. -There was documentation of blood glucose results of 85 at 7:30 am and 289 at 5:30 pm for 04/04/19. -There was documentation of blood glucose results of 118 at 7:30 am and a refusal at 5:30 pm for 04/06/19. -There was documentation of blood glucose results of 145 at 7:30 am and 101 at 5:30 pm for 04/07/19. -There was documentation of blood glucose	D932		

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D932	Continued From page 42 results of 116 at 7:30 am and 275 at 5:30 pm for 04/11/19. -There was documentation of blood glucose results of 103 at 7:30 am and 154 at 5:30 pm for 04/17/19. -There was documentation of blood glucose results of 90 at 7:30 am and 68 at 5:30 pm for 04/18/19. -There was documentation of blood glucose results of 79 at 7:30 am and 105 at 5:30 pm for 04/19/19. -There was documentation of blood glucose results of 74 at 7:30 am and 148 at 5:30 pm for 04/20/19. -There was documentation of blood glucose results of 74 at 7:30 am and 91 at 5:30 pm for 04/21/19. -There was documentation of blood glucose results of 81 at 7:30 am and 140 at 5:30 pm for 04/22/19. -There was documentation of blood glucose results of 79 at 7:30 am and 187 at 5:30 pm for 04/25/19. Observation of medication room for the 100 and 300 halls for 06/05/19 at 8:36 am revealed: -There were two plastic bins sitting for the counter of the medication room for either side of the sink. -The bins contained twelve black cases with a glucometer in each case and three glucometers without a case. -There were residents' names for each individual black case and the cases contained Brand B glucometers. -There were two Brand A glucometers in a plastic bin nearest the medication refrigerator. -There was one Brand A glucometer in the other plastic bin in the medication room. -The Brand A glucometers were not labeled with any residents' names.	D932		

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D932	Continued From page 43 -A medication aide (MA) used another resident's glucometer (Brand B) to perform a fingerstick blood glucose check for Resident #1 whose glucometer could not be located. -There was a container of name brand bleach wipes, Environmental Protection Agency (EPA) registered but not Occupational and Safety Health Administration (OSHA) approved, on the counter of the medication room. Interview with Resident #1 for 06/04/19 at 10:32 am revealed she had her blood glucose checked twice a day in the morning and at around 5:00 pm every day. Interview with Resident #1 for 06/06/19 at 4:04 pm revealed she did not recall the staff cleaning the glucometer for 06/05/19 in the morning or before that day. Refer to interview with the dayshift medication aide (MA) on 06/05/19 at 9:54 am. Refer to interview with another dayshift MA on 06/05/19 at 10:17 am. Refer to interview with the MA Supervisor on 06/05/19 at 11:48 am. Refer to interview with the Resident Care Coordinator (RCC) on 06/05/19 at 12:55 pm. Refer to interview with the Administrator on 06/05/19 at 1:13 pm. 2. Review of Resident#11's current FL-2 dated 02/25/19 revealed: -Diagnosis included diabetes. -There was an order for blood glucose checks three times a day.	D932		

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D932	Continued From page 44 Review of Resident #11's subsequent physician orders dated 06/03/19 revealed there was an order for blood glucose checks daily. Review of Resident #11's June 2019 electronic medication administration record (eMAR) revealed: -There was an entry for blood glucose check three times a day, scheduled for 7:30 am, 11:30 am, and 5:30 pm that was discontinued on 06/03/19. -There was another entry for blood glucose check daily, scheduled for 7:30 am that started 06/04/19. -There was documentation on 06/04/19 of a blood glucose of 114. -There was documentation on 06/05/19 of a blood glucose of 194. Observation of Resident #11 on 06/05/19 at 8:40 am revealed: -The MA attempted to use the resident's glucometer (Brand C) but it indicated an error message for the machine and then turned off. -The MA went to the Resident Care Coordinator's (RCC) office and then returned to the medication room. -The MA asked the Supervisor for assistance with the resident's glucometer. -The Supervisor took the resident's glucometer. -The MA reached for one of three Brand A glucometers in a plastic bin and set it for the counter. -She announced that she was using Brand A glucometer because the resident's glucometer was not working. -She then left the medication room and went to the RCC office again and returned approximately four minutes later.	D932		

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D932	Continued From page 45 -She announced she was using a disinfectant wipe to clean Brand A glucometer first before using it for the resident's fingerstick blood glucose check. -She wiped Brand A glucometer with the disinfectant wipe and used it to obtain a blood glucose reading for the resident. -A disposable lancet was used to prick the resident's finger to obtain the blood glucose reading. -The blood glucose reading was 194. Interview with Resident #11 on 06/06/19 at 4:41 pm revealed: -The medication aides (MA) did his blood glucose checks. -He did not know what glucometer was used the last time his blood sugar was taken. -He did not know if the glucometer was cleaned but he did not remember the staff cleaning the glucometer before his finger was pricked. Refer to interview with the dayshift medication aide (MA) on 06/05/19 at 9:54 am. Refer to interview with another dayshift MA on 06/05/19 at 10:17 am. Refer to interview with the MA Supervisor on 06/05/19 at 11:48 am. Refer to interview with the Resident Care Coordinator (RCC) on 06/05/19 at 12:55 pm. Refer to interview with the Administrator on 06/05/19 at 1:13 pm. _____ Interview with a day shift MA for 06/05/19 at 9:54 am revealed: -He had two and a half years of work experience	D932		

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D932	Continued From page 46 as a MA. -He was oriented at the facility by the medication aide (MA) Supervisor. -He followed the following steps to perform a blood glucose check: identified the resident, reviewed the electronic medication administration record (eMAR), confirmed the time of the ordered blood glucose check, confirmed the resident's identity, took the resident to the medication room, cleaned chosen finger with alcohol pad, get the resident's glucometer ready and insert the glucometer stick, wiped off glucometer with a sanitizing wipe, wash hands, put for gloves, stuck the side of the finger with a lancet, placed the drop of blood onto glucometer stick, wiped off the resident's finger with an alcohol pad, told the resident the glucometer reading, removed gloves and washed hands. -He admitted that he used another resident's glucometer (Brand B) when he obtained Resident #1's blood glucose at 8:36 am on 06/05/19. -He usually tried to find the resident's assigned glucometer, but he was not able to locate her glucometer. -He was supposed to use the "extra machines" (Brand A glucometers) for Resident #1, but he just grabbed an available glucometer in the plastic bin and used it for Resident #1's blood glucose check. -The protocol was to use the Brand A glucometers when you could not locate a resident's glucometer or a resident's glucometer was malfunctioning. -He was told to use Brand A glucometers when needed by the Supervisor when he was oriented two months ago. -The MA Supervisor taught him how to clean the glucometers and he had not seen any written instructions or a policy for glucometer use. -The MAs used the sanitizing wipes to clean the	D932		

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D932	Continued From page 47 glucometers. -He reported using a sanitizing wipe before checking Resident #1's blood glucose. -Brand B glucometers were assigned to the residents and placed in a black case with the resident's name written for it. -Brand B glucometer and Brand A were multi-user glucometers. -Brand A glucometers were never labeled with a resident's name or hallway assignment and did not belong to a specific resident. -Every MA who was on duty was responsible for ensuring the correct glucometer was used for residents. Interview with another day shift MA for 06/05/19 at 10:17 am revealed: -She had three years of work experience as a MA. -She was taught to use the "extra glucometers" (Brand A) when a resident's assigned glucometer was broken or missing. -She was also told by the MA Supervisor to use the "extra glucometers" (Brand A) when there was an issue with the resident's assigned glucometer as long as the glucometer was cleaned between residents. -She gave all broken glucometers to the Supervisor. -There were written instructions for cleaning for the insert in the box when a new glucometer was obtained. -There may be instructions in a notebook for the medication cart or posted on the wall of the medication room. -She was not sure of the location of the instructions for cleaning the glucometer. -She understood a multi-user glucometer to be one that was used for multiple residents. -Brand A was a multi- use glucometer because it	D932		

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D932	Continued From page 48	D932		

was the one used for several residents if needed.
-Brand A glucometers were never labeled with resident names or hallway assignment.
-The MAs were responsible for performing blood glucose checks.

Interview with the MA Supervisor for 06/05/19 at 11:48 am revealed:
-She was trained by staff who were no longer at the facility.
-She cleaned Brand B, a single use glucometer, with soap and water.
-She cleaned Brand A, a multi-use glucometer, with a sanitizing wipe.
-She obtained the instructions from the glucometer instruction book.
-She taught the MAs to use the extra glucometers, Brand A glucometers, if one of the resident's glucometers malfunctioned.
-She thought the Brand A glucometers could be used for multiple residents if it was cleaned in between uses.
-She did not check the Brand A glucometers and expected the MAs to tell her if there was something wrong with the glucometers.
-There were three glucometers that were missing or broken at that time and she planned to have them replaced with new Brand B glucometers.
-The MAs were responsible for ensuring the resident's assigned glucometer was used for blood glucose checks.

Interview with the Resident Care Coordinator (RCC) for 06/05/19 at 12:55 pm revealed:
-Each resident should have their own glucometer.
-Brand A was the glucometer used by the majority of the residents at one time.
-However, when they began to switch over to Brand B for each resident, the few remaining Brand A glucometers remained to be used if a

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D932	Continued From page 49 Brand B glucometer malfunctioned or could not be located. -The facility had extra Brand B glucometers that were kept locked in her office. -The extra Brand B glucometers could be used to replace the malfunctioning Brand B glucometers. -The Brand A glucometers were supposed to be cleaned force a week with a disinfectant. -The Brand B glucometers were supposed to be cleaned with soap and water. -She had spoken with Brand B company representative and he stated to clean the glucometer with soap and water even when using it with multiple residents. -The staff were supposed to only use the Brand A glucometers when it was an emergency and she preferred each resident had their own glucometer. -She planned to remove the Brand A glucometers from the medication rooms and expected the MAs to request when they needed a new glucometer for a resident. Interview with the Administrator for 06/05/19 at 1:13 pm revealed: -Most residents had their own glucometer. -She expected the MAs to clean the glucometer according to the manufacturer's guidelines. -The staff were able to use a "house glucometer" (extra glucometers, Brand A) if the glucometer was cleaned first according to the manufacturer's guidelines. -Brand A glucometers were used for more than fore resident, but it had to be cleaned. -The facility had extra Brand B glucometers that the RCC had access to in order to replace any broken resident glucometers. -The MAs were responsible for communicating to the MA Supervisor and RCC when a glucometer was malfunctioning and needed to be replaced.	D932		

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D932	Continued From page 50 The failure of the facility to implement infection control procedures consistent with CDC guidelines resulted in several residents receiving fingerstick blood sugar checks with the same glucometer. This failure exposed all diabetic residents with orders for blood glucose checks to increased risk of exposure to contracting a blood borne pathogens diseases. This failure was detrimental to the health, safety and welfare of the diabetic residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for 06/05/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, JULY 21, 2019.	D932		