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D 000	Initial Comments The Adult Care Licensure Section and the Rutherford County Department of Social Services conducted an annual survey on 07/31/19-08/01/19.	D 000		
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 ensure all residents were provided a non-disposable place setting consisting of a knife, fork, and spoon at each meal. The findings are: Interview with a medication aide (MA) on 07/31/19 at 9:15am revealed the current census was 19. Observation of the lunch meal service on 07/31/19 from 12:22pm to 1:00pm revealed: -There were 17 place settings prepared for the residents by staff. -All the place settings included a non-disposable fork and spoon.	D 287		

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-There were no knives.
-Residents were served turkey salad, cooked carrots, tossed salad with choice of dressing, a roll, and rice pudding.
-The residents did not ask for knives.
-Staff did not offer knives to the residents.
-Residents did not have any trouble eating their meal.

Observation of the breakfast meal service on 08/01/19 at 8:05am to 8:21am revealed:
-There were 10 residents in the dining room eating breakfast.
-All the place settings included a non-disposable fork and spoon.
-There were no knives.
-Residents were served scrambled eggs, cold cereal of choice with milk, toast with jelly, juice of choice, and coffee.
-The jelly was served as a small portion in the center of one of the divided tray partitions.
-The residents did not ask for knives.
-Staff did not offer knives to the residents.
-Residents did not have trouble eating their meal, but many left the jelly on their tray and did not eat it.

Interviews with six residents on 07/31/19 and 08/01/19 revealed:
- 6 of 6 residents routinely received a fork and spoon in their place settings at all meals.
-2 of 6 residents asked would use a knife at meals if they had one.
-Staff would give residents a knife if they asked for one.
-Staff cut up foods for the residents.

Interview with the Cook on 08/01/19 at 10:05am revealed:
-She had worked in the facility for two months.

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D 287	Continued From page 2 -Residents received a fork and spoon in their place settings at meals. -There was no reason she had not included the knife in the place settings. -"I just haven't thought about it." -"I know I am supposed to, but they haven't ever said anything about it." -Most of the residents did not need their meat cut up. -They cooked the meat until it "just falls apart" and was easily cut with a fork. -She had plenty knives available for all residents to have one at meals. -She would begin to include them in the place settings immediately at all meals. Interview with the facility's Registered Nurse Manager on 08/01/19 at 1:55pm revealed: -Staff routinely put out a fork and spoon in all resident place settings. -Knives were not routinely included in resident place settings. -"We cut up anything they need cut up." -"They can ask if they need one."	D 287		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 298		

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reviews, the facility failed to offer or make available three snacks a day to all residents and shown on the menu as snacks.

The findings are:

Interview with one resident on 07/31/19 at 9:20am revealed:
-The resident "sometimes" was given snack.
-"If you get hungry, you can ask for something."

Interview with a second resident on 07/31/19 at 9:32am revealed:
-Snacks were routinely offered at night.
-She would "sometimes" get hungry between the daytime meals.
-Snacks were not made available in the facility where residents could get them when they wanted them.
-The staff brought snacks "around on a cart usually at 9 or 9:30 at night."

Interview with a third resident on 07/31/19 at 9:46am revealed:
-"They do snacks at 1 or 2 o'clock in the afternoon."
-"They do them every other day."
-There was no morning snack offered.
-There was no evening snack offered.
-Snack was given out "one time a day unless you bring your own."
-There was a regular visitor to the facility and she "always brings us a snack such as candy or cookies."

Interview with a fourth resident on 07/31/19 at 10:00am revealed:
-Snacks were given out at between 8:00pm and 9:00pm every day.
-Snacks offered included sugar free strawberry

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wafer cookies, peanut butter crackers, cheese balls, pretzels, and cheese crackers, and sugar free soda.
-Snacks did not occur during the day unless the Registered Nurse Manager was in the building.

Interview with a fifth resident on 07/31/19 at 10:11am revealed:
-Snacks were offered at 9:00pm nightly,
-The resident did get hungry during the day between meals.
-The resident did not have a supply of own snack items.

Interview with a sixth resident on 07/31/19 at 3:45pm revealed:
-Snacks were only offered at night at 9:00pm.
-Juice, water, and diet soda were routinely offered as beverages for snack.
-Cookies or crackers were offered for food snack.

Review of the facility menu for 07/31/19 revealed:
-There were three snacks a day listed on the menu.
-The regular diet morning snack was peanut butter cracker or cheese cracker.
-The regular diet afternoon snack was starch and juice.
-The regular diet evening snack was popcorn and juice.

Observation of a personal care aide on 07/31/19 at 11:48am revealed:
-She was pushing a rolling cart down the hall stopping at resident rooms offering the residents snack.
-Residents had a choice of cheese crackers or peanut butter crackers for the food snack.
-Residents had a choice of apple juice or three different diet sodas.

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D 298	Continued From page 5 Interview with the personal care aide on 07/31/19 at 11:54am revealed: -Staff "usually do snack at 10:00am, 3:00pm and 9:00pm." -They were late in getting snack out today, because another staff member had to leave the facility briefly and had not yet returned. -Lunch would be served between 12:00pm and 12:30pm. Observation of a personal care aide on 07/31/19 at 2:55pm revealed: -She was pushing a rolling cart down the hall stopping at resident rooms offering the residents snack. -Residents had a choice of sugar free vanilla or chocolate wafers for the food snack. -Residents had a choice of apple juice or a choice of three different diet sodas. Observation of a personal care aide on 08/01/19 at 10:25am revealed: -She was pushing a rolling cart down the hall stopping at resident rooms offering the residents snack. -Residents had a choice of four different types of cookies for the food snack. -Residents had a choice of apple juice or a choice of three different diet sodas. Interview with the facility's Registered Nurse Manager on 08/01/19 at 1:55pm revealed: -It was the facility's policy to serve snacks three times a day. -She knew residents received snacks, because snacks were offered at activities. -For the residents who chose not to participate in an activity, their snack would be taken to them in their rooms.	D 298		

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D 306	10A NCAC 13F .0904(d)(3)(H) 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: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations interviews, and record reviews, the facility failed to ensure water was served to residents during the lunch and breakfast meal, in addition to other beverages. The findings are: Interview with a medication aide (MA) on 07/31/19 at 9:15am revealed the current census was 19. Observation of the lunch meal service on 07/31/19 at 12:22pm to 1:00pm revealed: -There were 17 place settings prepared for the residents by staff. -Pre-poured beverages were on the dining tables prior to residents entering the dining room. -All place settings had a one 12 oz. sized beverage cup. -There were 14 residents who were prepared tea. -One resident was pre-poured diet citrus flavored soda. -One resident was pre-poured milk. -One resident was pre-poured water. -None of the 17 residents served in the dining room received water in addition to their other beverages.	D 306		

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D 306	Continued From page 7 Review of the facility menu for 07/31/19 revealed "water is to be served with all diets at each meal." Observation of the breakfast meal service on 08/01/19 at 8:05am to 8:21am revealed: -There were 10 residents in the dining room eating breakfast. -All residents in the dining room had received a serving of either orange or apple juice and a serving of coffee. -None of the 10 residents served in the dining room received water in addition to their other beverages. Interviews with six residents on 07/31/19 and 08/01/19 revealed: -Five of six residents were not served water in addition to other beverages at meals. -Five of six residents would drink water if it were served in addition to other beverages. -One of six residents received water in addition to other beverages at meals. -"They just put it out for me." -Water was not served "unless you ask for it." -"I'm sure if any of them wanted water, they would give it to them." Interview with the Cook on 08/01/19 at 10:05am revealed: -She routinely put out one 12 oz. beverage cup at each resident place setting at meals. -She did not put out water in addition to other beverages for residents at meals. -"I would give them water, but none ever ask for water." -There was one resident who received water every meal. -"She drinks water anyway." Interview with the facility's Registered Nurse	D 306		

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D 306	Continued From page 8 Manager on 08/01/19 at 1:55pm revealed: -The facility policy was to serve water at all meals to all residents. -"They are supposed to take it to them." -"The residents will come and ask for it."	D 306		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer sliding scale insulin as prescribed for 2 of 2 sampled residents (Resident #1 and #4). The findings are: 1. Review of Resident #1's current FL2 dated 01/15/19 revealed diagnoses included type II diabetes mellitus, hemiplegia, sleep apnea, and	D 358		

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hyperlipidemia.

Review of Resident #1's signed physician order sheet dated 05/21/19 revealed:
-There was an order for Tresiba (controls blood sugar for 24 hours) 60 units daily in the morning.
-There was an order for fingerstick blood sugar tests (FSBS) three times a day with meals.
-There was an order for Novolog (rapid acting blood sugar control) 100 units/ml three times daily before meals using sliding scale (less than 150=0, 150-200=2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, greater than 400=12u).

Review of Resident #1's June 2019 Medication Administation Record (MAR) revealed:
-A computer generated entry for FSBS test scheduled at 7:30am, 11:30am, and 4:30pm.
-Handwritten beside the entry "See B/S Sheet."
-A computer generated entry for Novolog 100 units/ml Flex inject three times daily before meals using sliding scale less than 150=0, 150-200=2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, greater than 400=12u.
-Handwritten beside the entry "See Sliding Scale Insulin Sheet."

Review of Resident #1's June 2019 Sliding Scale Administration Record revealed:
-The handwritten record was dated 06/01/19 to 06/30/19.
-At the top of the form, the sliding scale was included for staff reference as follows less than 150=0, 150-200=2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, greater than 400=12u.
-FSBS were recorded three times a day at 8:00am, 12:00pm, and 5:00pm.
-The number of units of Novolog insulin

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administered per sliding scale were documented.
-On 06/02/19 at 12:00pm, FSBS 193, 4 units documented as administered, 2 units required.
-On 06/06/19 at 4:00pm, FSBS 167, 6 units documented as administered, 2 units required.
-On 06/07/19 at 12:00pm, FSBS 187, 6 units documented as administered, 2 units required.
-On 06/07/19 at 4:00pm, FSBS 193, 6 units documented as administered, 2 units required.
-On 06/11/19 at 12:00pm, FSBS 447, 8 units documented as administered, 12 units required.
-On 06/15/19 at 12:00pm, FSBS 302, 2 units documented as administered, 8 units required.
-On 06/15/19 at 5:00pm, FSBS 289, 10 units documented as administered, 6 units required.
-On 06/30/19 at 4:00pm , FSBS 176, 4 units documented as administered, 2 units required.
-There were 8 occurrences an incorrect dose of insulin was documented as administered out of 79 opportunities where insulin was required which was a medication error rate of 10%.
-The insulin errors were all documented administered by the same MA.

Interview with the medication aide who administered the incorrect insulin doses for Resident #1 on 08/01/19 at 12:09pm revealed:
-She had worked at the facility for "two to three months."
-She began administering medications to the residents in the middle of May 2019.
-"I know how to read the insulin scale."
-"I think I just recorded the wrong units when I recorded it."
-She may have gotten Resident #1's scale "mixed up" with Resident #4's scale.

Telephone interview with Resident #1's primary care Physician's Assistant on 08/01/19 at 1:54pm revealed:

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-The novolog was ordered for Resident #1 per sliding scale for the diagnoses of uncontrolled diabetes.
-If the resident was not getting the correct amount of insulin per the ordered scale, the resident's blood sugar "will be high"and would cause worsening symptoms and poor long-term control of the resident's diabetes.

Refer to the interview with the facility's Registered Nurse Manager on 08/01/19 at 1:55pm.

2. Review of Resident #4's current FL2 dated 01/08/19 revealed diagnoses included insulin dependent diabetes mellitus, schizoaffective disorder, and hypothyroidism.

Review of Resident #4's signed physician order sheet dated 05/29/19 revealed:
-There was an order for Levemir (controls blood sugar for 24 hours) 80 units daily at bedtime.
-There was an order for fingerstick blood sugar tests (FSBS) before meals and at bedtime.
-There was an order for Humalog (rapid acting blood sugar control) 100 units/ml three times daily before meals using sliding scale (less than 60=0, 161-200=4u, 201-240=6u, 241-280=8u, 281-320=10u, 321-360=12u, 361-400=14u, 401-440=16u, 441-480=18u, greater than 480=20u and call MD).

Observation of a medication aide (MA) on 07/31/19 at 11:46am revealed:
-She checked Resident #4's FSBS test and the result was 282.
-At 11:48am, the MA administered Humalog 10 units per sliding scale in the back of Resident #4's left upper arm.

Review of Resident #4's June 2019 Medication

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Administation Record (MAR) revealed:
-A computer generated entry for FSBS test scheduled at 7:30am, 11:30am, 4:30pm, and 8:00pm.
-Handwritten beside the entry "See B/S Sheets."
-A computer generated entry for Humalog 100 units/ml inject three times daily before meals using sliding scale less than 60=0, 161-200=4u, 201-240=6u, 241-280=8u, 281-320=10u, 321-360=12u, 361-400=14u, 401-440=16u, 441-480=18u, greater than 480=20u and call MD.
-Handwritten beside the entry "See Sliding Scale Insulin Sheet."

Review of Resident #4's June 2019 Sliding Scale Administration Record revealed:
-The handwritten record was dated 06/01/19 to 06/30/19.
-At the top of the form, the sliding scale was included for staff reference as follows less than 60=0, 161-200=4u, 201-240=6u, 241-280=8u, 281-320=10u, 321-360=12u, 361-400=14u, 401-440=16u, 441-480=18u, greater than 480=20u and call MD.
-FSBS were recorded three times a day at 8:00am, 12:00pm, 5:00pm, and 8:00pm.
-The number of units of Humalog insulin administered per sliding scale were documented.
-On 06/06/19 at 12:00pm, FSBS 396, 12 units documented as administered, 14 units required.
-On 06/07/19 at 5:00pm, FSBS 193, 6 units documented as administered, 4 units required.
-On 06/24/19 at 12:00pm, FSBS 359, 8 units documented as administered, 12 units required.
-There were 3 occurrences an incorrect dose of insulin was documented as administered out of 86 opportunities where insulin was required which was a medication error rate of 3%.
-The insulin errors were all documented administered by the same MA.

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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
D 358	Continued From page 13 Review of Resident #4's July 2019 MAR revealed: -A computer generated entry for FSBS test scheduled at 7:30am, 11:30am, 4:30pm, and 8:00pm. -Handwritten beside the entry "See B/S Sheets." -A computer generated entry for Humalog 100 units/ml inject three times daily before meals using sliding scale less than 60=0, 161-200=4u, 201-240=6u, 241-280=8u, 281-320=10u, 321-360=12u, 361-400=14u, 401-440=16u, 441-480=18u, greater than 480=20u and call MD. -Handwritten beside the entry "See Sliding Scale Insulin Sheet." Review of Resident #4's July 2019 Sliding Scale Administration Record revealed: -The handwritten record was dated 07/01/19 to 07/31/19. -At the top of the form, the sliding scale was included for staff reference as follows less than 60=0, 161-200=4u, 201-240=6u, 241-280=8u, 281-320=10u, 321-360=12u, 361-400=14u, 401-440=16u, 441-480=18u, greater than 480=20u and call MD. -FSBS were recorded three times a day at 8:00am, 12:00pm, 5:00pm, and 8:00pm. -The number of units of Humalog insulin administered per sliding scale were documented. -On 07/04/19 at 8:00am, FSBS 371, 8 units documented as administered, 14 units required. -On 07/08/19 at 8:00am, FSBS 298, 8 units documented as administered, 10 units required. -On 07/08/19 at 5:00pm, FSBS 390, 10 units documented as administered, 14 units required. -On 07/09/19 at 12:00pm, FSBS 276, 10 units documented as administered, 8 units required. -On 07/16/19 at 12:00pm, FSBS 431 , 14 units documented as administered, 16 units required. -On 07/25/19 at 4:00pm, FSBS 330, 6 units	D 358		

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documented as administered, 10 units required.
-On 07/26/19 at 12:00pm, FSBS 342, 10 units documented as administered, 12 units required.
-There were 7 occurrences an incorrect dose of insulin was documented as administered out of 91 opportunities where insulin was required which was a medication error rate of 8%.

Interview with the medication aide who administered the incorrect insulin doses for Resident #4 on 08/01/19 at 12:09pm revealed:
-She had worked at the facility for "two to three months."
-She began administering medications to the residents in the middle of May 2019.
-"I know how to read the insulin scale."
-"I think I just recorded the wrong units when I recorded it."

Telephone interview with Resident #4's Primary Care Physician's nurse on 08/01/19 at 1:14pm revealed:
-Resident #4 was ordered Humalog insulin per sliding scale for diabetes.
-Resident #4 could have episodes of high and low blood sugars as a result of not getting the correct sliding scale insulin dosage.
-Sliding scale insulin "needs to be given correctly with all meals."

Refer to the interview with the facility's Registered Nurse Manager on 08/01/19 at 1:55pm.

Interview with the facility's Registered Nurse Manager on 08/01/19 at 1:55pm revealed:
-The facility's policy was to administer medications as ordered.
-She was responsible for training all the medication aides.

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D 358	Continued From page 15 -She was responsible for going through and signing off of the medication clinical skills checklist with all medication aides before releasing them to administer medications. -She had trained them to check the FSBS and then look at the medication administration record to administer the medications.	D 358		
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 ensure 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 control and staff qualifications. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 2 of 3 diabetic residents sampled (Residents #4	D912		

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D912	Continued From page 16 and #5) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. [Refer to Tag 932 G.S 131D-4.4A(b) Adult Care Home Infection Prevention Requirements(Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff B) had completed their medication aide exam within 60 days of hire resulting in sliding scale insulin errors for two residents.[Refer to Tag 935 G.S. 131D-4.5B(b) Adult Care Homes Medication Aides Training and Competency (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.	D932		

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D932	Continued From page 17 d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, 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	D932		

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D932	Continued From page 18 2 of 3 diabetic residents sampled (Residents #4 and #5) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. The findings are: Review of the CDC (Center for Disease Control and Prevention) guidelines for infection control during blood glucose testing revealed: -Blood glucose monitoring devices (glucometers) were for single person use and should not be shared. -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 did not list disinfection information, the glucometer should not be shared. Review of the package insert for Brand A glucometer revealed: -On page one, Brand A "blood glucose monitoring system is intended to be used by a single person and should not be shared." -On page three, do not share the glucometer due to the risk of infection from bloodborne pathogens. -On page three, "Cleaning and disinfecting the meter and lancing device destroys most, but not necessarily all bloodborne pathogens." -On page three, "If the meter is being operated by a second person who is providing testing assistance to the user, the meter and lancing device should be cleaned and disinfected prior to use by the second person." Observation of one medication aide (MA) performing blood sugar monitoring on 07/31/19 at 11:37am revealed: -The MA removed one unlabeled zippered black	D932		

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pouch from the third drawer on the medication cart and placed it on the right side of the top of the medication cart.
-The MA then removed a second unlabeled zippered black pouch from the third drawer on the medication cart and placed it on the left side of the top of the medication cart.
-The pouch on the right contained one Brand A glucometer labeled on the back with a computer generated pharmacy label with Resident #4's name, an unlabeled lancing pen, and a bottle of test strips.
-The pouch on the left contained one Brand A glucometer labeled on the back with with a computer generated pharmacy label with Resident #5's name and a bottle of test strips.
-The MA then swapped the glucometer and lancing pen from the pouch on the right and placed it in the pouch on the left.
-The MA then moved the glucometer labeled with Resident #5's name from the pouch on the left and placed it in the pouch on the right.

Interview with the medication aide on 07/31/19 at 11:45am revealed:
-She swapped the glucometer and lancing pen from the pouch on the right to the pouch on the left because she "got nervous cause they weren't labeled."
-Resident #5's pouch (on left) did not have a lancing pen.
-She did not share lancing pens between residents.
-She used a single use safety lancet to obtain blood samples for blood glucose monitoring for Resident #5.
-Resident #5's "lancing pen tore up, but we use the safety lancets."

Interview with a second medication aide on

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08/01/19 at 9:30am revealed:
-She routinely performed blood glucose monitoring for Resident #4 at 8:00pm.
-Resident #4's glucometer was labeled with resident's name on the back.
-Resident #4's black zippered pouch was stored in the cart in the area where the resident's medications were stored.
-She "made sure" she had "the right one."
-She had been trained never to share glucometers between residents.
-"It's important, so we don't contaminate the other person."
-She had infection control training, but could not remember the last time she had the training.
-She was "not sure" why the histories on the glucometers did not match the documented blood sugar results recorded.
-"I always use the right meter for the right person."

1. Review of Resident #5's current FL2 dated 03/04/19 revealed:
-Diagnoses included non-insulin dependent diabetes mellitus, hypertension, hyperparathyroidism, and chronic back pain.
-There was an order for blood sugar monitoring every other day alternating times.

Review of Resident #5's physician order sheet dated 05/01/19 revealed there was an order for blood sugar monitoring every 2 days alternating morning fasting and evening.

Review of the history in a glucometer labeled with Resident #5's name on 07/31/19 at 2:15pm revealed:
-The blood glucose values recorded in the glucometer's history compared to the values documented on Resident #5's blood sugar log

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dated 07/11/19 to 07/31/19 were inconsistent.
-The blood sugar dated 07/31 at 8:03am was 242. The result documented on 07/31 at 8:00am was 141.
-The blood sugar dated 07/30 at 8:37am was 343. There was no result documented.
-The blood sugar dated 07/30 at 4:37pm was 316. There was no result documented.
-The blood sugar dated 07/30 11:26am was 358. There was no result documented.
-The blood sugar dated 07/30 at 7:45am was 264. There was no result documented.
-The blood sugar dated 07/29 at 8:40pm was 238. There was no result documented.
-The blood sugar dated 07/29 at 4:33pm was 235. The result documented on 07/29 at 4:30pm was 346.
-The blood sugar dated 07/29 at 11:38am was 247. There was no result documented.
-The blood sugar dated 07/29 at 7:49am was 170. There was no result documented.
-The blood sugar dated 07/28 at 8:30pm was 219. There was no result documented.
-The blood sugar dated 07/28 at 3:56pm was 249. There was no result documented.
-The blood sugar dated 07/28 at 12:34pm was 175. There was no result documented.
-The blood sugar dated 07/27 at 8:45pm was 323. There was no result documented.
-The blood sugar dated 07/27 at 5:12pm was 354. There was no result documented.
-The blood sugar dated 07/27 at 12:08pm was 222. There was no result documented.
-The blood sugar dated 07/27 at 8:37am was 233. The result documented on 07/27 at 9:00am was 134.
-The blood sugar dated 07/21 at 3:19pm was 347. There was no result documented.
-The blood sugar dated 07/21 at 1:08pm was 299. There was no result documented.

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-The blood sugar dated 07/21 at 7:59am was 228. There was no result documented.
-The blood sugar dated 07/20 at 7:58pm was 313. There was no result documented.
-The blood sugar dated 07/20 at 3:43pm was 299. There was no result documented.
-The blood sugar dated 07/20 at 11:36am was 342. There was no result documented.
-The blood sugar dated 07/19 at 11:51am was 338. The result documented on 07/19 at 8:00am was 338.
-The blood sugar dated 07/17 at 4:33pm was 246. The result documented on 07/17 at 4:30pm was 246.
-The blood sugar dated 07/15 at 12:08pm was 318. The result documented on 07/15 at 12:00pm was 318.
-The blood sugar dated 07/13 at 4:39pm was 165. The result documented on 07/13 at 4:30pm was 165.
-The blood sugar dated 07/11 at 9:38am was 302. The result documented on 07/11 at 8:00am was 302.

Interview with Resident #5 on 07/31/19 at 3:52pm revealed:
-Staff used the safety single use lancet (short purple and orange device) to obtain blood samples to monitor her blood sugars.
-Staff performed the blood glucose monitoring for the resident.
-She did not know what glucometer staff used to check her blood sugar.

Interview with the facility's Registered Nurse Manager on 07/31/19 at 3:30pm revealed:
-She thought her medication aides were getting Resident #4 and #5's glucometers "mixed up" because the labels on the glucometers were "small" and the "bins are close in the cart."

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D932	Continued From page 23 Refer to the interview with the facility's Registered Nurse Manager on 08/01/19 at 1:45pm. 2. Review of Resident #4's current FL2 dated 01/08/19 revealed diagnoses included insulin dependent diabetes mellitus, schizoaffective disorder, and hypothyroidism. Review of Resident #4's signed physician order sheet dated 05/29/19 revealed there was an order for blood glucose monitoring before meals and at bedtime at 7:30am, 11:30am, 4:30pm, and 8:00pm. Review of the history in a glucometer labeled with Resident #4's name on 07/31/19 at 2:26pm revealed: -The blood glucose values recorded in the glucometer's history compared to the values documented on Resident #4's Sliding Scale Administration Record (SSAR) dated 07/01/19 to 07/31/19 were inconsistent. -The blood sugar in the glucometer on 07/31 at 8:48am was 141. The result documented on the SSAR 07/31 at 8:00am was 403. -The blood sugar in the glucometer on 07/29 at 4:42pm was 346. The result documented on the SSAR 07/29 at 4:00pm was 235. -The blood sugar in the glucometer on 07/26 at 8:21pm was 322. The result documented on the SSAR 07/26 at 8:00pm was 299. -The blood sugar in the glucometer on 07/09 at 5:05pm was 340. The result documented on the SSAR 07/09 at 5:00pm was 360. -The blood sugar in the glucometer on 07/09 at 1:30pm was 421. The result documented on the SSAR 07/09 at 12:00pm was 276. -The blood sugar in the glucometer on 07/09 at 8:31am was 276. The result documented on the	D932		

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SSAR 07/09 at 8:00am was 254.
-The blood sugar in the glucometer on 07/08 at 8:27am was 268. The result documented on the SSAR 07/08 at 8:00am was 298.
-The blood sugar in the glucometer on 07/04 at 4:11pm was 307. The result documented on the SSAR 07/04 at 5:00 pm was 301.

Interview with Resident #4 on 07/31/19 at 9:20am revealed:
-Staff performed blood glucose monitoring "two to three" times a day.
-Staff used the "short one" or the safety single use lancet device to obtain blood samples to monitor her blood sugars.
-She did not know what glucometer staff used to check her blood sugar.

Interview with the facility's Registered Nurse Manager on 07/31/19 at 3:30pm revealed:
-She thought her medication aides were getting Resident #4 and #5's glucometers "mixed up" because the labels on the glucometers were "small" and the "bins are close in the cart."
-In June 2019, there were some blood glucose results "missing" from Resident #4's Sliding Scale Administration Record and she went back through the glucometer history and filled them in so she could fax the results to the physician.
-Resident #4 had gotten a brand new glucometer on 06/12/19.
-She must have checked the results to fill in the values missing on the Sliding Scale Administration Record from Resident #4's old meter.
-When she had gone through the history on Resident #4's glucometer "there wasn't anything that caught my eye."

Refer to the interview with the facility's Registered

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D932	Continued From page 25 Nurse Manager on 08/01/19 at 1:45pm. Interview with the facility's Registered Nurse Manager on 08/01/19 at 1:45pm revealed: -She was responsible for all the training of the medication aides. -She performed the Medication Administration Clinical Skill Checklist with each Medication Aide. -She was responsible for the Licensed Health Professional Support training for medication aides for all personal care tasks including blood sugar monitoring. -She taught all of the medication aides on an individual basis. -She had taught them to use resident specific equipment for blood sugar monitoring. The facility failed to maintain infection control measures consistent with CDC guidelines for blood sugar monitoring. The facility's failure resulted in the risk of exposure and transmission of blood borne illnesses which was detrimental to the health, safety, and welfare of two diabetic residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/31/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 15, 2019.	D932		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency	D935		

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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
D935	Continued From page 26 G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081007	A. BUILDING: _____ B. WING _____	C 08/01/2019

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D935	Continued From page 27 accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff B) had completed their medication aide exam within 60 days of hire resulting in sliding scale insulin errors for two residents. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired 04/01/19 as a personal care aide. -There was documentation Staff B had completed the 15 hour state approved medication training on 05/22/19. -There was documentation the Medication Administration Clinical Skill Checklist was completed on 05/24/19 and again on 07/24/19. -There was no documentation of of successful completion of the medication aide exam. Review of one resident's June 2019 Sliding Scale Insulin Administration Records revealed: -There were 8 occurrences an incorrect dose of insulin was documented as administered by Staff B. -This resulted in a monthly sliding scale error rate of 10% for the month of June 2019.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D935	Continued From page 28	D935		

Review of a second resident's June and July 2019 Sliding Scale Insulin Administration Records revealed:
-In June, there were 3 occurrences an incorrect dose of insulin was documented as administered by Staff B.
-This resulted in a monthly sliding scale error rate of 3% for the month of June 2019.
-In July, there were 4 of the 7 occurrences an incorrect dose of insulin was documented as administered were administered by Staff B.
-This resulted in a monthly sliding scale error rate of 8% for the month of July 2019.

Interview with Staff B, MA, on 08/01/19 at 12:09pm revealed:
-She had worked at the facility for "two to three months."
-She began administering medications to the residents in the middle of May 2019.
-She had taken the medication aide exam on 06/27/19.
-She had not passed the medication aide exam on 06/27/19.
-She had been rescheduled to retake the medication aide exam on 07/30/19, but arrived late to the test site and had been unable to take the exam.
-"I know how to read the insulin scale."
-"I think I just recorded the wrong units when I recorded it."
-She may have gotten two residents scales "mixed up".

Interview with the Registered Nurse Manager on 08/01/19 at 11:00am revealed:
-Staff B had taken the medication aide exam and "failed it by one question."
-She had rescheduled Staff B to retake the exam "twice again."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D935	Continued From page 29 -Staff B had arrived late to both of those scheduled exams and had not been allowed to take the exam. -She had performed the Medication Administration Clinical Skill Checklist again with Staff B on 07/24/19. -Staff B had continued to administer medications after 60 days of the job description change to medication aide. _____ The failure of the facility to ensure Staff B, medication aide, had successfully completed the medication aide exam within 60 days of the job description change to a medication aide resulted in sliding scale insulin errors for two residents which was detrimental to the health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D on 08/01/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 15, 2019.	D935		