STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096008	A. BUILDING: _____ B. WING _____	02/06/2020

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WOODARD CARE	2050 US 70 WEST HWY GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on January 4, 2020 through January 5, 2020 with exit by telephone on January 6, 2020.	D 000		
D 022	10A NCAC 13G .0214 Suspension Of Admission 10A NCAC 13G .0214 Suspension Of Admission (a) Either the Secretary or his designee shall notify the domiciliary home by certified mail of the decision to suspend admissions. Such notice will include: (1) the period of the suspension, (2) factual allegations, (3) citation of statutes and rules alleged to be violated, (4) notice of the facility's right to contested case hearing or the suspension. (b) The suspension will be effective when the notice is served or on the date specified in the notice of suspension, whichever is later. The suspension will remain effective for the period specified in the notice or until the facility demonstrates to the Secretary or his designee that conditions are no longer detrimental to the health and safety of the residents. (c) The home shall not admit new residents during the effective date of the suspension. (d) Any action taken by the Division of Facility Services to revoke a home's license or to reduce the license to a provisional license shall be accompanied by a recommendation to the Secretary or his designee to suspend new admissions. A suspension may be ordered without the license being affected.	D 022		

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D 022	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to comply with Suspension of Admissions (SOA) licensure action dated 11/05/19 as evidenced by admitting two residents into the facility after the SOA was in effect. The findings are: 1. Review of Resident #11's FL2 dated 01/09/20 revealed diagnoses included heart failure, hyperlipidemia, essential primary hypertension, chronic obstructive pulmonary disease, chronic respiratory failure, gastroesophageal reflux disease, and chronic kidney disease. Review of the Resident Register revealed Resident #11 was admitted on 12/30/19. Interview with the Business Office Manager (BOM) on 02/05/20 at 9:27am revealed: -Resident #11 moved from a local skilled nursing facility. -Resident #11 was evaluated one week (she did not recall the date) and moved into the facility the following week. Refer to the interview with the BOM on 02/05/20 at 9:27am. Refer to the interview with the Facility Manager (FM) on 02/05/20 at 9:50am. Refer to the telephone interview with the Adult Home Specialist (AHS) on 02/06/20 at 11:15am. Refer to the telephone interview with the facility's accountant on 02/06/20 at 11:20am.	D 022		

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D 022	Continued From page 2 2. Review of Resident #12's FL2 dated 01/09/20 revealed diagnoses included vascular dementia, hypertension, hypothyroidism, cerebrovascular disease and gastroesophageal reflux disease. Review of the Resident Register revealed Resident #12 was admitted on 01/07/20. Interview with the Business Office Manager (BOM) on 02/05/20 at 9:27am revealed: -Resident #12 moved from his home to the facility. -Resident #12 was brought to the facility by his family member to be evaluated for admission and moved in about two weeks later. Refer to the interview with the BOM on 02/05/20 at 9:27am. Refer to the interview with the FM on 02/05/20 at 9:50am. Refer to the telephone interview with the Adult Home Specialist (AHS) on 02/06/20 at 11:15am. Refer to the telephone interview with the facility's accountant on 02/06/20 at 11:20am. _____ Interview with the BOM on 02/05/20 at 9:27am revealed: -She was responsible for admissions to the facility. -She did not know the facility had a suspension of admissions (SOA). -She should have known about the SOA. -She was not aware the FM had signed for the certified letter on 11/14/19 notifying the facility of the SOA. Interview with the FM on 02/05/20 at 9:50am	D 022		

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D 022	Continued From page 3 revealed: -The BOM was responsible for admissions. -She did not receive a letter related to the SOA. -The AHS did not tell her they could not admit residents to this facility. -She could not explain why her signature was on the certified letter notification and receipt dated 11/14/19. -She did not recall signing for anything related to the SOA. Telephone interview with the AHS on 02/06/20 at 11:15am revealed: -On 11/05/19, she called the BOM to tell her the facility was on a list that indicated the facility had a SOA. -The AHS reminded the FM the facility could not have any admissions until the SOA was lifted. Telephone interview with the facility's accountant on 02/06/20 at 11:20am revealed: -The FM forwarded the SOA letter to him, but he did not recall the date.	D 022		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.	D 113		

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D 113	Continued From page 4 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure hot water temperatures were maintained between 100 and 116 degrees (°) Fahrenheit (F) as evidenced by hot water temperatures lower than 100°F for 2 of 2 water fixtures (sink and shower) in the female residents' common bathroom on the special care unit (SCU). The findings are: Observation of the female residents' common bathroom on the SCU on 02/04/20 at 9:57am revealed: -The hot water ran for approximately 8 minutes. -The hot water temperature in the sink was 91.9 degrees. -The hot water temperature in the shower was 87 degrees. Interview with a personal care aide (PCA) on 02/04/20 at 9:57am revealed: -One resident had "just finished" her bath. -The water usually felt "lukewarm." Interview with a second PCA on 02/04/20 at 10:00am revealed: -One resident had a bath today, 02/04/20. -She did not have to use the cold-water faucet, "just straight hot water." -Most of the residents tolerated just hot water. -Sometimes a resident might think the water was too hot, and she would add cold water. -She thought the water could be hotter, but "I guess it is ok for this age group." Interview with a third PCA on 02/04/20 at 6:00pm revealed: -She had helped the residents with showers in the	D 113		

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common bathroom.
-She thought the hot water was a medium temperature.
-She thought it would be better if the water was hotter.

Interview with a resident on 02/04/20 at 6:07pm revealed:
-She used the shower in the female residents' common bathroom on the special care unit.
-There had been several times she thought the water was too chilly, but it was "doable."
-She thought the water could be warmer.

Second observation of the female residents' common bathroom on the SCU on 02/05/20 at 9:01am revealed:
-The hot water ran for approximately 6 minutes.
-The hot water temperature in the sink was 96 degrees.
-The hot water temperature in the shower was 97 degrees.

Interview with maintenance staff on 02/05/20 at 8:45am revealed:
-The heating element was replaced approximately one week ago.
-The hot water heater had two elements; only one element was replaced.
-He did not check the water temperature after replacing the element.

Interview with a medication aide (MA)/Supervisor on 02/05/20 at 8:51am revealed:
-A heating element had "gone bad" in the hot water heater about a week ago.
-She had not checked the water temperature.

Interview with a hospice agency PCA on 02/05/20 at 8:56am revealed:

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-She had assisted a resident with a sink bath today, 02/05/20.
-The water was warm; the water was not hot.
-She had assisted a resident with a shower on Monday, 02/03/20 and the water was warm.
-She had only used the hot water on 02/03/20; she did not have to add cold water to the hot water on 02/03/20.

Interview with the Facility Manager on 02/05/20 at 9:02am revealed:
-The water temperature should be between 100-116 degrees F.
-She was not aware of any problems with the water temperature in the female residences' common bathroom on the SCU.
-The Supervisors were responsible for checking water temperatures monthly and documenting the temperatures.
-The hot water heater was recently repaired.
-The water temperature log book was kept in the medication room.

Interview with two MA/Supervisors on 02/05/20 at 9:08am revealed:
-They had not checked the water temperatures in 2020.
-They usually checked the water temperatures once a month.
-No one was assigned to check the water temperatures; they "just did it."
-They usually used a thermometer from the kitchen.
-They did not know where the water temperature logbook was located.

On 02/05/20 at 9:15am, the facility's digital thermometer and the surveyor's thermometer were calibrated using an ice water slurry. The facility's thermometer displayed 33.1 degrees F

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D 113	Continued From page 7 and the surveyor's thermometer displayed 32.2 degrees F. Observation of the water temperature at the sink in the female residents' common bathroom on the SCU on 02/05/20 at 9:17am revealed the temperature was 93.7 on the facility thermometer and 92.3 on the surveyor's thermometer. Second interview with the Facility Manager on 02/05/20 at 9:17am revealed: -She did not check behind the Supervisors to make sure water temperatures were being checked. -She expected the Supervisors to check the water temperature monthly and to notify her if there was a problem with the water temperature. -She would locate the water temperature log book. Review of water temperature logs for the female common bathroom on the SCU revealed: -In Jaunary 2019, the temperature was documented as 108 degrees in the bath. -In February 2019, the temperature was documented as 106.5 degrees in the bath and 109.1 degrees in the sink. -In March 2019, the temperature was documented as 110 degrees in the bath and 109.2 degrees in the sink. -There were no other water temperature logs available for review.	D 113		
D 150	.0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff	D 150		

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who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.
(b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure 1 of 6 sampled staff (Staff C) who provided personal care to residents had documentation of successful completion of an 80-hour personal care training and competency evaluation program.

The findings are:

Review of Staff C's, personnel record revealed:
-Staff C was hired in 2002 as a housekeeper.
-Staff C was rehired in 2011 as a cook.
-There was no documentation Staff C was a personal care aide (PCA).
-There was no documentation Staff C had

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completed an 80-hour personal care training and competency evaluation program.

Interview with a Supervisor on 02/04/20 at 10:30am revealed:
-The facility had 3 sections, the male special care unit (SCU), the female SCU and the assisted living (AL).
-The male SCU was staffed with one PCA.
-The female SCU was staffed with two PCAs.
-Staff C was assigned to the male SCU today, 02/04/20.

Observation of the male SCU between 9:45am and 10:05am revealed there was one staff , Staff C, in the male SCU.

Observation of the female SCU on 02/04/20 at 5:52pm revealed:
-There were two staff in the female SCU.
-Staff C assisted residents with meals and toileting.

Interview with Staff C on 02/05/20 at 12:04pm revealed:
-She worked as a personal care aide in the SCU.
-She could not remember how long she had been providing resident care but thought "about 8 years."
-She assisted residents with baths, incontinence care, showers, and transfers.
-She had not taken a PCA class.
-She learned how to care of the residents from other staff.

Interview with the Administrator on 02/05/20 at 12:58pm revealed:
-She knew Staff C did not have PCA training.
-Staff C worked in dietary and housekeeping.
-She thought when the facility was short-staffed

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D 150	Continued From page 10 she could use staff to assist in other areas. -She did not know Staff C had to have PCA training to be able to assist with resident care. -Staff C had only filled in 3-4 times. -Staff C never worked alone and was always paired with a PCA.	D 150		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to assure the refrigerator was maintained at a proper temperature; date and label stored food; and keep food storage containers, storage racks and the ice machine free of contamination. The findings are: 1. Observation on 02/04/20 at 11:45am of the refrigerator revealed: -There was no thermometer. -The Kitchen Manager/cook (KM) was unable to locate a thermometer in the refrigerator. Observation on 02/04/20 at 5:35pm of a surveyor's thermometer revealed the temperature of the refrigerator was 60 degrees Fahrenheit (F). Refer to interview on 02/04/20 at 9:40am with the	D 283		

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D 283	Continued From page 11 KM. Interview on 02/04/20 at 5:35pm with the KM revealed she thought cold food was to be maintained between 60 degrees F and 70 Degrees F. Refer to interview on 2/05/20 at 1:06pm and 1:30pm with the Facility Manager. 2. Observation on 02/04/20 at 9:40am and 10:35am of the food pantry revealed: -There was labeled grits wrapped in tin foil on the top shelf that was not dated. -There was an undated, opened box of cake mix covered with a brown, sticky residue with an unlabeled, not dated plastic bag inside with a hole opening into the cake mix on the second shelf. -There was a plastic five pound tub of mashed potato granules on the second shelf that was opened, unlabeled, uncovered and not dated. -There were two bulk bins labeled chicken breading and hush puppy mix on the second shelf that were not dated. -There were two bulk bins labeled biscuit mix and flour on the third shelf that were not dated. -There were two bulk bins labeled grits and rice on the bottom shelf that were not dated. Observation on 02/04/20 at 5:15pm and 6:05pm of the kitchen refrigerator revealed: -There was a container of unlabeled, undated gelatin on the bottom right self. -The top middle shelf had 3 plastic 1 gallon containers of an unlabeled, undated brown liquid. -The top middle shelf had 1 pitcher of an unlabeled, undated brown liquid -The middle third rack had 1/2 pitcher of an unlabeled, undated brown liquid -There was an unlabeled, undated bowl of food	D 283		

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on the second left shelf.
-There was a block of unlabeled, undated sliced cheese on the top left shelf.

Interview on 02/05/20 at 4:20pm with a dietary aide identifying unlabeled, undated food in the refrigerator revealed:
-The brown liquid in containers and pitchers was tea made 02/05/20.
-The food in the bowl was applesauce.

Refer to interview on 02/04/20 at 9:40am with the Kitchen Manager/cook (KM).

Interview on 02/04/20 at 9:40am with the KM revealed:
-She was aware opened food items were to be labeled and dated.

Interviews with the KM on 02/05/20 at 3:35pm and 4:15pm revealed:
-She was aware opened food items were to be labeled and dated.
-Food was to be discarded on the third day.

Refer to interview on 2/05/20 at 1:06pm and 1:30pm with the Facility Manager (FM).

Interview on 02/05/20 at 1:05pm and 1:30pm with the FM reveled:
-She had directed the KM to discard food that had been opened four days earlier.
-She had directed the KM all opened food was to be covered, labeled and dated when in the refrigerators.
-She had directed the KM to date and label opened food containers.

3. Observation on 02/04/20 at 9:40am and 10:35am of the food pantry revealed:

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D 283	Continued From page 13 -The bottom shelf had an open plastic box with small black particles covering the sides and bottom and two grill blocks. -The right pantry floor was covered with a black film, black and white objects and on the floor was a box labeled shortening and oil with a plastic container inside. -The top shelf was dusty, covered with a white powdered substance and the galvanization was chipped. -The bottom shelf was dusty, rusted, had a sticky film and the galvanization was chipped. -The floor under the left rack had an unopened can of chocolate pudding, was scattered with debris, covered in a black film and an opened bag of miniature marshmallows was strewn across the floor. -There was a blackish gray film with spilled cereal on the floor under the left rack. There were two bulk bins labeled grits and rice on the bottom shelf that were covered on the top and side with dust and a sticky, brownish film. Observation on 02/04/20 at 11:45am of the refrigerator revealed: -A shelf rack for the refrigerator was lying on the pantry floor which was covered with dust, debris and a sticky, blackish film. -Ice approximately 2 inches deep covered approximately ½ of the top of the interior of the refrigerator. -The door handles on the refrigerator were covered with a sticky film. Observation on 02/04/20 at 5:15pm and 6:05pm of the kitchen refrigerator revealed the door handles on the refrigerator were covered with a sticky film. Refer to interview on 02/04/20 at 9:40am with the	D 283		

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D 283	Continued From page 14 Kitchen Manager/cook (KM). Interview on 02/04/20 at 9:40am with the KM revealed: -There was no documented cleaning schedule. -She had no documented procedure to follow to clean the pantry storage room, racks or bins. -The bins were washed in the kitchen sink. -She wiped, cleaned, and sanitized items one hour a day and before she left in the evening based on her observations and experience. -Once a month the racks in the pantry were wiped down but not moved away from the wall during the cleaning process. -The floors in the pantry were swept after lunch. -The pantry floors were swept and mopped once in the evening before the end of the cook's shift. -The pantry floors were mopped when a spill occurred. Interviews with the KM on 02/05/20 at 3:35pm and 4:15pm revealed: -There were no written schedule for cleaning the refrigerators. -She did not maintain a log revealing when the refrigerators were cleaned. -There was not a documented kitchen cleaning schedule. -Cooks and dietary aides were to wipe away spills in the refrigerators as they occurred. -She wiped spilled materials off the refrigerators every day. -Cooks and dietary aides were to wipe down the refrigerators daily. -Refrigerators were to be cleaned once a week by dietary aides. -A variety of cleaners were available to clean the refrigerators. Refer to interview on 2/05/20 at 1:06pm and	D 283		

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D 283	Continued From page 15 1:30pm with the Facility Manager (FM). Interview on 02/05/20 at 1:05pm and 1:30pm with the FM revealed: -There were no written assignments for cleaning the refrigerators. -Dietary aides were to wipe spills off the refrigerators when they occurred and with a cleanser or sanitizer every four days. -She went in the kitchen one time a month after the dietary staff cleaned the kitchen areas. -She had directed the KM to clean the kitchen areas daily and deep clean every four days. -She had directed the KM every four days all plastic containers in the pantry were to be taken apart and washed in the sink. -Dietary staff were directed to clean the racks but there was not an established schedule when racks were to be cleaned. -Racks were not removed from the wall when they were cleaned. -The floor under the racks were to be cleaned daily. Observation of the ice machine in the kitchen on 02/04/20 at 11:06am revealed: -There was a brown, black colored build-up that covered the top interior front lip and ice drop of the ice machine from the left to right sides of the interior bin. -Thick, slimy, discolored water was dripping from a pipe on the bottom of the ice machine into an exterior drain hole. Record review of receipts from the company contracted to clean and sanitize the ice machine revealed one receipt dated 6/24/19 for cleaning and sanitizing services. Interview on 02/05/20 at 4:15pm with the KM	D 283		

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D 283	Continued From page 16	D 283		

revealed:
-She was not responsible for cleaning the ice machine.
-Dietary aides were responsible for cleaning the ice machine.
-She did not have a documented procedure to follow to clean the ice machine.
-She did not have a schedule to clean the ice maker.

Interview on 02/05/20 at 4:25pm with a dietary aide revealed:
-She had no documented procedure to follow to clean and sanitize the ice maker.
-She emptied the ice from the machine every day.
-She used dish detergent and bleach to wipe the outside of the ice machine daily.
-She cleaned the inside of the ice machine by wiping with dish detergent and bleach when the machine appeared very dirty.
-She had never looked under the interior front lip of the ice machine.
-She would not clean under the interior front lip or ice drop area as she was afraid her hand would get stuck.
-She never checked or cleaned under the ice machine to observe if water leaving the ice machine appeared slimy or smelled foul.

Interview on 02/05/20 at 1:15pm with the FM revealed:
-The ice maker drain should be cleaned by the cook.
-She was not aware when the ice machine was last cleaned.
-Recently a new company was contracted to clean the ice machine.
-The new company was to come to clean the ice machine when they were requested by telephone call.

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D 283	Continued From page 17 -She did not have a schedule specifying when to call to request ice machine cleaning. -She believed the ice machine had not been cleaned in six months or more. Attempted telephone interview 02/05/20 at 6:30pm with the Administrator was unsuccessful. _____ _____ Interview on 02/04/20 at 9:40am with the Kitchen Manager/cook revealed: -She worked four days on and four days off. -She alternated with another cook. -She was responsible for the kitchen and cleanliness of the kitchen. Interview on 02/05/20 at 1:06pm and 1:30pm with the Facility Manager revealed she went in the kitchen once or twice a week but was not inspecting the kitchen area.	D 283		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain a substitution log to document substitute menu items to indicate the foods served to residents. The findings are:	D 292		

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D 292	Continued From page 18 Observation of the kitchen on 02/04/20 at 9:44am revealed: -There was a five-week menu for the kitchen staff to reference. -There was a hand-written piece of paper on top of the menu with six meals written on it. Review of the substitution log on 02/04/20 at 9:45am revealed the last substitution was documented in 05/16/17. Interview with the Kitchen Manager (KM) on 02/04/20 at 9:44am revealed: -She was following week one on the five-week menu cycle. -The piece of paper with the six meals were lunch and dinner for 02/03/20, 02/04/20 and 02/05/20. -She did not follow the five-week dietitian approved breakfast menus because she made her own menu to follow; the only explanation was because she "just did it that way". -She used the dietitian approved five-week menu for lunch and dinner and replaced items as she wanted. -She chose the items for the meals and placed a food order based on the menu she wrote. -She re-wrote the menu because she thought it was okay to give "like items" to the residents. -She knew she could serve "meat for meat, vegetable for vegetable and dessert for dessert" and she had to serve bread at every meal. -She did not keep the hand-written menus she created, and she did not document the meal changes on a substitution log. -She did not have anything documented on the substitution log since November 2019. -She thought a substitution was when food items were damaged during delivery and could not be used or when something was burned.	D 292		

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D 292	Continued From page 19 -She did not realize when she changed an item on the menu it was considered a substitution. -She did not think when she replaced a starch for a starch or a meat for a meat item it was considered a substitution. -She frequently changed the menu because she thought it was okay to change out items; she could not give any other reasons for changing items on the menus. Review of the Tuesday breakfast meal on the five-week menu revealed cereal, French toast, breakfast meat, margarine with syrup, and 2% milk were to be served. Second interview with the KM on 02/04/20 at 10:00am revealed: -She served the residents two pancakes, two sausage links, coffee, juice, milk and water for breakfast that morning. -The week five menu for that morning was French toast, breakfast meat, coffee, juice, and milk. -She did not document on the substitution log that she substituted the French toast for pancakes because she thought she could change items on the menu if they were similar. -She could not explain why she served the pancakes instead of the French toast. Review of the 02/04/20 Tuesday lunch meal on the five-week menu revealed cube steak with gravy, baked sweet potato half, greens, hot spiced apples, a biscuit, and margarine were to be served; beverages were not listed on the menu for lunch. Observation of the hand-written lunch menu for Tuesday revealed stew beef, rice, lima beans, cake and a biscuit were to be served.	D 292		

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D 292	Continued From page 20 Observation of the lunch meal on 02/04/20 at 12:11pm revealed cubed stew meat in a brown gravy over rice, lima beans, a dinner roll, a piece of cake with frosting, tea, water and milk were served to the residents. Review of the 02/04/20 Tuesday dinner meal on the five-week menu revealed a soft taco, fiesta rice, roasted corn with black beans, churros and 2% milk were to be served. Observation of the hand-written dinner menu for Tuesday revealed hot ham and cheese on a bun, tater tots, corn and mixed fruit were to be served. Observation of the dinner meal on 02/04/20 at 5:50pm revealed ham and cheese on a bun, French fried potatoes, corn, fruit cocktail, water, tea and milk were served. Third interview with the KM on 02/04/20 at 4:58pm revealed: -She did not know lima beans were a starch; she thought lima beans were a vegetable. -She had to substitute a dessert for a dessert; she did not know she had to substitute a fruit for fruit on the menu. -She did not know how many carbohydrates she had served the residents for the lunch meal that day; she said maybe one or two. -The residents liked the ham and cheese better than the tacos; she tried to serve them what they would eat which was why she changed the menu items for lunch and dinner. -She did not document on the substitution log the items she had changed [substituted] on the menu for lunch and dinner. Interview on 02/05/20 at 3:35pm with the KM revealed:	D 292		

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D 292	Continued From page 21 -She had been informed by the Facility Manager (FM) on 02/05/20 to start a record of food substitutions and the dates of the substitutions. -She had not been aware a substitution log was required before 02/05/20. -She started writing a food substitution log on 02/05/20. -She had written in the log food substitutions made on 02/04/20 and 02/05/20. -There had not been a substitution log kept since she started as KM. Interview with the FM on 02/05/20 at 21:21pm revealed: -She was aware menu substitutions were to be documented. -The KM did not have an item list to reference for substitutions. -The KM had a spiral bound notebook for documenting substitutions; the date, the meal and the item substituted were supposed to be documented. -She did not check the substitution book or the menu; she let the KM handle the substitutions. -She did not have a schedule to check the substitution log book. -The KM should be following the five-week menu cycle and order food based on the menu. -She expected substitutions to be kept to a minimum; substitutions should have been made only once or twice a month. -She had never been informed by the KM that food items had been substituted. -She was not aware the KM at times substituted the entire meal. -She knew acceptable substitutions were a starch for a starch, a vegetable for a vegetable, a meat item for a like meat item and a vegetable for a vegetable. -She was not aware how often menu substitutions	D 292		

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D 292	Continued From page 22 had occurred. -Her expectation was that menu substitutions were not to occur unless the food was not available. -She was aware the KM was not following the menu for breakfast. -She had told the KM that menus were to be followed.	D 292		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and	D 468		

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D 468	Continued From page 23 supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 6 sampled staff (Staff D) received 6-hours of special care unit (SCU) orientation training within the first week of hire and 3 of 6 sampled staff (Staff B, Staff C, and Staff F) who worked in the SCU had completed an additional 20 hours of training within the first six months of employment. The findings are: 1. Review of Staff D, personnel care aide's (PCA) personnel record revealed: -Staff D was hired on 10/07/19. -There was no documentation Staff D had any SCU training. Attempted telephone interview with Staff D on 02/05/20 at 12:28pm was unsuccessful. Interview with the Facility Manager 02/05/20 at 12:58pm revealed: -Staff D had 6-hours of SCU training. -She did not know why there was no documentation in Staff D's personnel record related to the SCU training. Refer to the interview with the Facility Manager on 02/05/20 at 12:58pm. 2. Review of Staff B, medication aide (MA)/Supervisor's personnel record revealed:	D 468		

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D 468	Continued From page 24 -Staff B was hired as a personal care aide on 11/17/16. -Staff B was promoted to a MA/Supervisor in 03/2017. -There was documentation Staff B had 6-hours of SCU training on 11/10/16. -There was no documentation Staff B completed the additional required 20 hours of SCU training during her first six months of employment. Telephone interview with Staff B on 02/05/20 at 1:36pm revealed: -She had SCU training every year; she did not know how many hours the class was. -She did not recall if anyone told her she had to have an additional 20-hours during her first six months of employment at the facility. Refer to the interview with the Facility Manager on 02/05/20 at 12:58pm. 3. Review of Staff C, housekeeper/cook's personnel record revealed: -Staff C was hired as a housekeeper in 2002 and a cook in 2011. -There was documentation Staff C had 6-hours of SCU training on 01/18/16. -There was no documentation for an additional 20-hours of SCU training within 6-months of employment. Interview with Staff C on 02/05/20 at 12:04pm revealed: -She worked as a personal care aide in the SCU. -She could not remember how long she had been providing resident care but thought "about 8 years." -She had SCU training every year. -She did not know how many hours of dementia care she had or how many hours of SCU training	D 468		

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D 468	Continued From page 25 was required. Refer to the interview with the Facility Manager on 02/05/20 at 12:58pm. 4. Review of Staff F, personnel care aide's (PCA) personnel record revealed: -Staff F was hired on 02/16/18. There was documentation Staff F had 6-hours of SCU training on 03/30/18. -There was no documentation Staff F completed the additional required 20 hours of SCU training during her first six months of employment. Attempted telephone interview with Staff F on 02/05/20 at 12:35pm was unsuccessful. Refer to the interview with the Facility Manager on 02/05/20 at 12:58pm. Interview with the Facility Manager on 02/05/20 at 12:58pm revealed: -She was responsible for personnel records. -She knew the staff who worked in the SCU were required to have dementia-specific training. -She knew the staff was required to have six hours of dementia training the first week. -She did not know the staff was required to have an additional twenty hours of dementia-specific training within six months.	D 468		
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.	D912		

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D912	Continued From page 26 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure every resident received care and services which were adequate, appropriate, and in compliance with relevant state rules and regulations for Adult Care Home Infection Prevention Requirements The findings are: Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 6 of 6 sampled diabetic residents (#3, #6, #7, #8, #9, and #10) whose blood sugars were checked by staff and resulted in the shared use of glucometers. [Refer to Tag D 0113 10A NCAC 13F G.S. 131D-4.4A Adult Care Home 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 (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	D932		

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D932	Continued From page 27 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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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 6 of 6 sampled diabetic residents (#3, #6, #7, #8, #9, and #10) whose blood sugars were checked by staff and resulted in the shared use of glucometers.

The findings are:

Review of the Center for Disease Control (CDC) and Prevention guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents.

Observation of medication cart A on 02/05/20 at 6:17pm revealed:
-There was a clear plastic container with a resident's name on it.
-There was an unlabeled glucometer (Brand D), a lancet device, and single-use lancets in the plastic container.
-There was a another clear plastic container with another resident's name on it.
-There was an unlabeled glucometer (Brand B)

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and single-use lancets in the plastic container.
-There was a third clear plastic container with a third resident's name on it.
-There was an unlabeled glucometer (Brand C), a lancet device with blood residue on it, and single-use lancets in the plastic container.
-The medication aide (MA) used an alcohol swab to clean the lancet device.

Observation of medication cart B on 02/05/20 at 6:32pm revealed:
-There was a clear plastic container with Resident #6's name on it.
-There was an unlabeled glucometer (Brand B) and a lancet device in the plastic container.
-There was another clear plastic bag with Resident #9's name on it.
-There was an unlabeled glucometer (Brand A) and a lancet device in the plastic bag.

Review of the manufacturer's user manual for the Brand A glucometer revealed:
-The glucometer stored up to 10 results in the order they were measured.
-The glucometer was intended to be used by a single person and should not be shared.
-All parts of the glucometer were considered biohazardous and could potentially transmit infectious disease, even after pre-cleaning and disinfection.
-If a second person provided testing assistance, the meter was to be disinfected prior to use.
-The disinfection procedure prevented transmission of bloodborne pathogens.
-The name of the recommended germicidal wipe was listed.

Review of the maufacturer's user manual for Brand B glucometer revealed:
-The glucometer was intended to be used by a

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single person and not to be shared.
-The glucometer was for one person use only, do not share your meter with anyone.
-Do not use on multiple patients.
-All parts of the blood glucose monitoring system could carry blood-borne pathogens after use, even after cleaning and disinfecting.
-Cleaning and disinfecting the meter destroy most, but not necessarily all, blood-borne pathogens.
-Wash your hands thoroughly with soap and warm water before and after handling the meter, lancing device, lancets, or test strips as contact with blood presents an infection risk.
-Clean and disinfect immediately after getting any blood on the meter or if the meter is dirty.
-Clean and disinfect the meter at least once a week.
-If the meter was being operated by a second person who provides testing assistance, the meter and lancet device should be disinfected prior to use by the second person.
-Clean and disinfect the meter with only with named wipes.

Telephone interview with a representative from the manufacturer for Brand C glucometer on 02/11/20 at 9:00am revealed Brand C was a single use glucometer and should not be used between multiple residents.

Review of the manufacturer's user manual for Brand D glucometer revealed:
-The meter was indicated for use in a home setting or in a clinical setting by healthcare professionals.
-The meter was for single-patient use only and should never be shared with another person, even a family member.
-All parts of the kit were considered biohazards

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and could potentially transmit infectious diseases even after performing cleaning and disinfection.
-Clean the outside of the meter with a damp cloth only; decontamination should not be needed if the meter instructions were followed correctly.

1. Review of Resident #7's current FL-2 dated 01/09/20 revealed:
-Diagnoses included diabetes type II, hypothyroidism, hyperlipidemia, hypokalemia, paranoid schizophrenia, essential hypertension, and cerebral infarction.
-There was an order to check finger stick blood sugar (FSBS) three times daily.

Review of Resident #7's physician's order dated 11/06/19 revealed an order for FSBS four times a day.

Observation of a finger stick blood sugar (FSBS) check for Resident #7 on 02/04/20 at 5:18pm revealed:
-The medication aide (MA) retrieved a glucometer (Brand B) from a clear plastic box labeled with Resident #7's name on it.
-The glucometer was not labeled with Resident #7's name.
-The MA cleaned her hands with hand sanitizer that was on top of the medication cart.
-The MA went into Resident #7's room, put on gloves, and placed a test strip into the glucometer.
-The MA swabbed Resident #7's left index finger with an alcohol wipe and used a single-use lancet to obtain a blood sample.
-The MA placed a drop of blood on the test strip that was in the glucometer.
-The result of the FSBS was 129.
-The MA placed the test strip and the lancet into the sharps container.

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D932	Continued From page 32 -The MA placed the glucometer into the clear plastic container labeled with Resident #7's name on it. -The MA removed the gloves and sanitized her hands. Review of the memory data for Resident #7's Brand B glucometer on 02/05/20 revealed: -The date on the glucometer reflected the current date of 02/05/20. -There were 24 readings in the memory from 12/01/19-12/06/19. -Twelve of the 24 readings in the memory that were not recorded on Resident #7's FSBS log. -There were 23 readings in the memory from 12/07/19-12/31/19. -None of the readings in the memory were recorded on Resident #7's FSBS log; Resident #7 was out of the facility from 12/07/19-12/31/19. -There were 8 readings in the memory from 01/01/20-01/07/20. -None of the readings in the memory were recorded on Resident #7's FSBS from 01/01/20-01/07/20; Resident #7 was out of the facility from 01/01/20-01/08/20. -There were multiple glucometer readings on 01/09/20, 01/11/20, 01/13/20, 01/14/20, 01/21/20,01/28/20, and 01/29/20 that were done within one to thirty minutes apart; the reading was not high or low to justify a recheck of Resident #7's FSBS. -There were 14 readings in the memory from 02/01/20-02/05/20. -There were 9 of the 14 readings in the memory that did not match the resident's blood sugar documented on the February 2020 FSBS log. Review of Resident #7's December 2019 FSBS log revealed: -The resident's blood sugar was checked four	D932		

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times daily scheduled at 7:00am, 11:00am, 4:30pm, and 8:00pm.
-There were 21 blood sugars documented from 12/01/19-12/06/19 but there were only 12 of the readings in the glucometer.

Review of Resident #7's January 2020 FSBS log revealed:
-The resident's blood sugar was checked three times daily scheduled at 7:00am, 11:00am, and 3:00pm.
-There were 69 blood sugars documented from 01/08/20-01/31/20 but there were only 34 of the readings in the glucometer.

Review of Resident #7's February 2020 FSBS log revealed:
-The resident's blood sugar was checked three times daily scheduled at 7:00am, 11:00am, and 3:00pm.
-There were 14 blood sugars documented from 02/01/20-02/05/20 but there were only 5 of the readings in the glucometer.

Refer to the interview with a medication aide (MA) on 02/04/20 at 5:18pm.

Refer to the interview with a MA on 02/05/20 at 6:32pm.

Refer to the interview with the Facility Manager on 02/05/20 at 6:13pm.

Refer to the interview with the BOM on 02/05/20 at 6:37pm.

2. Review of Resident #6's current FL2 dated 02/04/20 revealed:
-Diagnoses included vascular dementia, diabetes type 2, schizophrenia, and hypertension.

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D932	Continued From page 34 -There was an order to check finger stick blood sugar (FSBS) twice a day. Review of Resident #6's physician's orders dated 08/07/19 revealed an order to check FSBS twice a day. Review of the memory data for Resident #6's Brand B glucometer on 02/05/20 revealed: -The date on the glucometer reflected the current date of 02/05/20. -There were 77 readings in the memory from 01/01/20-01/20/20. -Forty-four of the 77 readings in the memory from 01/01/20-01/20/20 were not recorded on Resident #6's January 2020 FSBS flowsheet. -There were 6 readings in the memory from 01/21/20-01/23/20 that were not recorded on Resident #6's January 2020 flowsheet. -There were 5 readings in the memory from 01/24/20-01/26/20 that were not recorded on Resident #6's January 2020 flowsheet. -The result from 01/30/20 recorded on Resident #6's January 2020 flowsheet was not in the memory. -There were 10 readings in the memory from 02/01/20-02/05/20. -There were 4 readings in the memory from 02/01/20-02/05/20 that were not recorded on Resident #6's February 2020 FSBS flowsheet. Review of Resident #6's medication administration record (MAR) for January 2020 revealed: -There was an entry for FSBS twice a day scheduled at 7:00am and 4:00pm -Resident #6's FSBS was obtained at 7:00am from 01/01/20-01/21/20 and 01/31/20 and at 4:00pm from 01/01/20-01/20/20 and 01/31/20. -Resident #6 was hospitalized on 01/21/20.	D932		

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-Resident #6 was sent home from the hospital at 5:00pm on 01/23/20.
-Resident #6 was hospitalized again on 01/24/20.

Review of Resident #6's MAR for February 2020 revealed:
-There was an entry for FSBS twice a day scheduled at 7:00am and 4:00pm.
-Resident #6's FSBS was obtained at 7:00am from 02/01/20-02/05/20 and at 4:00pm from 02/01/20-02/04/20.

Review of Resident #6's January 2020 FSBS log revealed:
-There was documentation of the results of Resident #6's FSBS performed at 7:00am from 01/01/20-01/20/20 and 01/30/20.
-There was documentation of the results of Resident #6's FSBS performed at 4:00pm from 01/01/20-01/10/20, 01/12/20-01/20/20 and 01/31/20.
-There was documentation of the results of Resident #6's FSBS performed at 5:00pm from 01/23/20.
-The results documented on 01/01/20, 01/04/20, 01/08/20, 01/10/20, 01/20/20, and 01/30/20 were not in the glucometer for those dates.

Review of Resident #6's February 2020 FSBS log revealed:
-There was documentation of the results of Resident #6's FSBS performed at 7:00am from 02/01/20-02/05/20.
-There was documentation of the results of Resident #6's FSBS performed at 4:00pm from 02/01/20-02/04/20.
-The results documented on 02/01/20 were not in the glucometer for those dates.

Interview with the Facility Manager on 02/05/20 at

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D932	Continued From page 36 3:37pm revealed Resident #6 was out of the facility from 01/21/20-01/29/20. Refer to the interview with a medication aide (MA) on 02/04/20 at 5:18pm. Refer to the interview with a MA on 02/05/20 at 6:32pm. Refer to the interview with the Facility Manager on 02/05/20 at 6:13pm. Refer to the interview with the BOM on 02/05/20 at 6:37pm. 3. Review of Resident #10's current FL-2 dated 08/21/19 revealed: -Diagnoses included diabetes type II, hypothyroidism, hypertension, gastroesophageal reflux disease, heart failure, and schizoaffective disorder. -There was an order to check finger stick blood sugar (FSBS) daily and as needed (prn). Review of the memory data for Resident #10's Brand C glucometer on 02/05/20 revealed: -The date on the glucometer reflected the current date of 02/05/20. -There were 24 readings in the memory from 12/01/19-12/31/19. -There were 5 of the 24 readings in the memory that were not recorded on Resident #10's December 2019 FSBS log. -There were 30 readings in the memory from 01/01/20-01/31/20. -There were 15 of the 30 readings in the memory that were not recorded on Resident #10's January 2020 FSBS log from 01/01/20-01/31/20. -On 01/08/20, 01/12/20, and 01/26/20, there were 2 readings in Resident #10's glucometer; only 1	D932		

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D932	Continued From page 37 of the readings each day matched the FSBS for Resident #10 documented on the January FSBS log. Review of Resident #10's December 2019 FSBS log revealed: -The resident's blood sugar was checked daily scheduled at 7:00am. -There were 31 blood sugars documented from 12/01/19-12/31/19. -There were only 19 of the readings in the glucometer. -There were 5 readings documented that did not match the glucometer's memory. -There were no readings in the glucometer for seven readings. Review of Resident #10's January 2020 FSBS log revealed: -The resident's blood sugar was checked daily scheduled at 7:00am. -There were 31 blood sugars documented from 01/08/20-01/31/20 but there were only 34 of the readings in the glucometer. -There were 31 blood sugars documented from 01/08/20-01/31/20 but there were only 13 of the readings in the glucometer. -There were 15 readings documented that did not match the glucometer readings. -Three were documented that there were not in the glucometer for those dates. Refer to the interview with a medication aide (MA) on 02/04/20 at 5:18pm. Refer to the interview with a MA on 02/05/20 at 6:32pm. Refer to the interview with the Facility Manager on 02/05/20 at 6:13pm.	D932		

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D932	Continued From page 38 Refer to the interview with the BOM on 02/05/20 at 6:37pm. 4. Review of Resident #3's current FL-2 dated 03/13/19 revealed: -Diagnoses included diabetes mellitus type two, schizophrenia, hypertension, gastroesophageal reflux (GERD), seizure, history of abdominal aortic aneurysm, depression and anxiety. -There was an order to check finger stick blood sugars (FSBS) twice daily. Review of the memory data for Resident #3's Brand D glucometer on 02/05/20 revealed: -The date and time on the glucometer reflected the current date and time. -There were no readings from 12/24/19 to 01/15/20. -There were 11 readings for December 2019 that ranged from 108 to 224. -There were 26 readings for January 2020 that ranged from 122 to 333. -There were 6 readings for February 2020 that ranged from 184 to 274. Review of Resident #3's medication administration record (MAR) for February 2020 revealed there was an entry for FSBS to be checked twice daily at 7:00am and 8:00pm. Review of Resident #3's December 2019 FSBS log revealed: -FSBS were documented twice a day at 7:00am and 8:00pm. -There were 61 entries on the log that ranged from 79 to 365. -There were 7 documented blood sugar readings that matched the glucometer readings for December 2019. -There were readings documented from 12/01/19	D932		

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D932	Continued From page 39 to 12/16/19 and 12/25/19 to 12/31/19 that were not in the glucometer memory. Review of Resident #3's January 2020 FSBS log revealed: -FSBS were documented twice a day at 7:00am and 8:00pm. -There were 62 entries on the log that ranged from 106 to 333. -There were fourteen documented blood sugar readings that matched the glucometer readings for January 2020. -There were readings documented from 01/01/20 to 01/15/20 that were not in the glucometer memory. Review of Resident #3's February 2020 FSBS log revealed: -FSBS were documented twice a day at 7:00am and 8:00pm. -There were nine entries on the log that ranged from 140 to 321. -None of the entries matched the readings in the glucometer for February 2020. Interview with Resident #3 on 02/05/20 at 7:26pm revealed: -His FSBS was checked twice a day. -The color of his glucometer was red but his FSBS was not always checked with his red glucometer. -Sometimes the MAs used a glucometer that was black. -The black glucometer was used more than his red one to check his FSBS. -The MAs were good about taking his FSBS twice a day; he did not have to ask them or remind them to do the FSBS. -He thought the "black one" was used the night before.	D932		

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D932	Continued From page 40 Interview with a medication aide (MA) on 02/05/20 at 9:15am revealed: -Resident #3 received a new glucometer about three months ago; she purchased it over the counter, and it was red. -Resident #3 was about to run out of strips for his old glucometer and could not get replacement strips so she purchase the new glucometer. -Resident #3 had an order for FSBS twice a day; once in the morning and once in the evening. -She strictly used Resident #3's new glucometer for him. -The test strips for Resident #3's glucometer only fit his meter; his strips did not fit any of the other residents' glucometers. -She documented Resident #3's FSBS on a "blood sugar sheet"; there was one glucometer per resident and one sheet per resident. Interview with the Facility Manager (FM) on 02/05/20 at 9:49am revealed Resident #3's glucometer was purchased over the counter about three months ago because the facility could not get test strips for his old glucometer anymore. Second interview with the MA on 02/05/20 at 3:55pm revealed: -She did not know what happened to the missing readings in Resident #3's glucometer for December 2019 and January 2020. -She knew the FSBS were done because they were documented. -She did not use anyone else's glucometer to take FSBS for Resident #3. -If she had to use another resident's glucometer, she knew to clean it properly with an alcohol wipe. -She did not use one resident's glucometer for another resident.	D932		

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	HAL096008	A. BUILDING: _____ B. WING _____	02/06/2020

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D932	Continued From page 41 -The residents' names were on the boxes the glucometers were stored in, but the names were not on the individual glucometers. Telephone interview with a second MA on 02/05/20 at 4:22pm revealed: -Resident #3 had an order for FSBS twice a day; she obtained the FSBS for Resident #3 at night around 8:00pm. -She used the glucometer from the box with Resident #3's name on it. -Resident #3's glucometer only used test strips for his glucometer; he could not use strips from another resident's glucometer. -She had to use another [named] resident's glucometer when Resident #3 ran out of test strips for his glucometer. -She thought she used the named resident's glucometer for Resident #3 a couple of weeks ago for probably two weeks. -She cleaned the named resident's glucometer after every use with a cotton ball soaked with alcohol by "wiping the whole machine". -She used the named resident's glucometer for Resident #3 because it was convenient since they were near each other. -She thought it was "okay" to use another resident's glucometer for Resident #3 because she cleaned it after she used it. Refere to interview with the Facility Manager on 02/05/20 at 6:13pm. Refer to interview with the Business Office Manager (BOM) on 02/05/20 at 6:37am. 5. Review of Resident #9's current FL2 dated 12/18/19 revealed: -Diagnoses included bipolar disorder, schizophrenic disorder, acute hepatic	D932		

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D932	Continued From page 42	D932		

encephalopathy, gastroesophageal reflux disease (GERD), and chronic obstructive pulmonary disease (COPD).
-There was an order for finger stick blood sugar (FSBS) once a day.

Review of the memory data for Resident #9's Brand A glucometer on 02/05/20 revealed:
-The glucometer did not record the date or time.
-There were 10 results in the memory.
-There were 2 readings in the memory not recorded on Resident #9's January 2020 flowsheet.

Review of Resident #9's January 2020 FSBS log revealed:
-There was documentation of the results of Resident #9's FSBS from 01/01/20-01/31/20.
-The FSBS results documented from 01/21/20-01/23/20, 01/25/20-01/27/20, and 01/31/20 were not in the glucometer's memory.
-The FSBS result documented on 01/07/20 was in the memory of the glucometer indicated to be used on another resident.

Review of Resident #9's February 2020 FSBS log revealed:
-There was documentation of the results of Resident #9's FSBS from 02/01/20-02/05/20.
-The results documented on 02/04/20 and 02/05/20 were not in the glucometer's memory.

Refer to the interview with a medication aide (MA) on 02/04/20 at 5:18pm.

Refer to the interview with a MA on 02/05/20 at 6:32pm.

Refer to interview with the Facility Manager on 02/05/20 at 6:13pm.

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D932	Continued From page 43 Refer to interview with the Business Office Manager (BOM) on 02/05/20 at 6:37am. 6. Review of Resident #12's current FL-2 dated 01/02/20 revealed: -Diagnoses included diabetes mellitus type two, schizophrenia, hyperglycemia and acute kidney injury. -There was an order for finger stick blood sugars (FSBS) twice daily. Review of the memory data for Resident #12's Brand B glucometer on 02/05/20 revealed: -The date and time on the glucometer reflected the current date and time. -There were 71 readings from 01/09/20 to 01/31/20 that ranged from 64 to 305. -There were 12 readings from 02/01/20 to 02/05/20 that ranged from 74 to 321. Review of Resident #12's February 2020 FSBS log revealed: -FSBS were documented twice a day at 7:00am and 8:00pm. -There were 12 entries on the log that ranged from 74 to 267. -Ten of the entries matched the blood sugar readings in the glucometer for February 2020. Review of Resident #12's January 2020 FSBS log revealed: -FSBS were documented twice a day at 7:00am and 8:00pm. -There were 62 entries on the log that ranged from 87 to 320. -There were 27 documented blood sugar readings that matched the glucometer readings for January 2020.	D932		

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D932	Continued From page 44 Telephone interview with a medication aide (MA) on 02/05/20 at 4:22pm revealed: -Resident #12 had an order for FSBS twice a day; she obtained the FSBS for Resident #12 in the evening around 8:00pm. -She had used Resident #12's glucometer when she ran out of test strips for another [named] resident's FSBS. -She thought she used Resident #12's glucometer for another resident a couple of weeks ago for probably two weeks. -She thought it would be alright to use Resident #12's glucometer as long as she cleaned it with a cotton ball soaked in alcohol after she used it on another resident. Refer to the interview with a medication aide (MA) on 02/04/20 at 5:18pm. Refer to the interview with a MA on 02/05/20 at 6:32pm. Refer to interview with the Facility Manager on 02/05/20 at 6:13pm. Refer to interview with the Business Office Manager (BOM) on 02/05/20 at 6:37am. _____ Interview with a medication aide (MA) on 02/04/20 at 5:18pm revealed: -Each resident had a personal glucometer. -The glucometers were cleaned weekly. Interview with the Facility Manager on 02/05/20 at 6:13pm revealed: -She did not know glucometers were being shared between residents. -She did not think there was a policy on the use of glucometers. -All residents with an order for FSBS had their	D932		

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D932	Continued From page 45 own glucometer. -The medication aides (MA) were responsible for checking FSBS. -The MAs knew not to share glucometers between residents. -There would be no time that it would be acceptable to use the same glucometer on multiple residents. -If a resident was not in the facility, she would expect there to be no readings on the dates the resident was out of the facility. -The FSBS log should match the glucometer readings for each resident. -If a resident's glucometer was not working or there were no house supplies to use for that glucometer, she would expect the MA to notify the primary care physician (PCP) of missed FSBS checks and document why the FSBS was not completed. -She would not expect the MA to use another resident's glucometer. -The Business Office Manager (BOM) set-up all residents with orders for FSBS to receive a glucometer and glucometer supplies through a mail-order company. -She purchased containers, labeled with each resident's name, and stressed to the MAs not to use supplies from other residents. -There was a time when residents' supplies were not available, and the MAs were borrowing strips from other residents, That resident would run out before insurance would authorize ordering more, and that was why they set everyone up with a mail-order company. -There was no excuse for a resident to run out of supplies since the mail order supply was set up, she thought in September 2019. Interview with a MA on 02/05/20 at 6:32pm revealed:	D932		

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D932	Continued From page 46 -The glucometers were not shared among the residents. -She had never used the same glucometer on multiple residents. -She had not heard of any MA using the same glucometer on multiple residents. -She cleaned the glucometer and multiple use lancet device with an alcohol swab before and after each use. -Her supervisor told her to clean the glucometer with each use. -Batteries were kept on hand for each glucometer, so there would be no need to share a glucometer. -She never encountered a glucometer that was inoperable. Interview with the BOM on 02/05/20 at 6:37pm revealed: -She had every resident with orders for FSBS to receive supplies via mail order. -She thought it was in August 2019 or September 2019. _____ The failure of the facility to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines resulted in staff sharing glucometers for 6 of 6 sampled diabetic residents. There were multiple FSBS readings recorded in the memory of the 6 residents' glucometers that did not match FSBS readings documented on their FSBS logs. This failure was detrimental to the health , safety, and welfare of the residents due to possible exposure of blood borne pathogens, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/05/20 for this violation.	D932		

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D932	Continued From page 47 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 21.2020.	D932		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency 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.	D935		

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D935	Continued From page 48 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 accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 5 sampled staff (Staff F) who administered medications had completed the 5, 10, or 15-hour medication administration training courses and completed a medication clinical skills competency validation prior to administering medications. The findings are: Review of Staff B, medication aide's (MA) personnel record revealed: -Staff B was hired on 11/17/16 as a personal care aide (PCA). -Staff B was promoted to a MA/Supervisor on 03/2017. -There was documentation Staff B passed the written medication examination on 01/20/17. -There was no documentation Staff B completed 5, 10, or 15-hours of training. Review of a resident's Medication Administration	D935		

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D935	Continued From page 49 Record (MAR) revealed: -Staff B documented the administration of medication on 17 days in December 2019. -Staff B documented the administration of medication on 15 days in January 2020. -Staff B documented the administration of medication on 4 days in February 2020. Telephone interview with Staff B on 02/05/20 at 1:36pm revealed: -She worked as a MA. -She took a two-day class when she worked in a mental health facility and passed a test to be able to pass medications. -She did not recall if she received any type of certificate. -She did not recall if anyone had asked her for documentation for the completion of a medication aide class. -She studied on her own for the state medication examination. -She had not taken a 15-hour medication class since she started working at this facility. Interview with the Facility Manager on 02/05/20 at 12:58pm revealed: -She was responsible for the personnel records. -She audited the personnel records when she became the Facility Manager. -Staff B was already in a MA/Supervisor role when she took over as the Facility Manager. -She did not notice Staff B did not have documentation of a 15-hour MA class.	D935		