STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068024	A. BUILDING: _____ B. WING _____	02/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT GREEN OF CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 survey on February 19-21, 2020.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record review, and interviews, the facility failed to assure the facility was clean and free of hazards as evidenced by the presence of bedbug activity in resident rooms #117, #212, and #311. The findings are: Review of the pest control invoice dated 12/06/19 revealed: -In November the 100 halls along with the outside perimeter was treated. -In December the 300 hall, the perimeter of the building and unit 213 were treated. -There was no explanation of what type of pest the building was treated for. Review of the pest control invoice dated 01/03/20 revealed: -The monthly pest control visit was made. -There was no indication of what areas were	D 079		

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treated.
-There was no explanation of what type of pest the building was treated for.

Review of the pest control invoice dated 02/07/20 revealed:
-The pest control visit for the month was made.
-There was no indication of what areas were treated.
-There was no explanation of what type of pest the building was treated for.

Attempted telephone interviews with the facility contracted pest control company on 02/21/20 at 9:15 am, 9:17 am, 9:30 am, 10:15 am, 12:47 pm and 3:15 pm .

Review of the facility's bed bug protocol revealed:
Process for treating for bed bugs:
-Inspect rooms weekly and upon complaint or sighting. If bed bugs are found follow the following steps.
-Bag up all trash and debris in the room and bring it directly to the dumpster.
-Have an aide bring the resident directly to shower, put the resident clothes in a clear trash bad and bring it directly to the dryer and dry on high heat for 35-40 minutes.
-Do a skin assessment of the resident for any signs of bites. When complete, help the resident wash off thoroughly in water as hot as the resident can tolerate. Bring a set of clothes that have been dried for at least 35 minutes on high heat for the resident to put on after showering. (Do not allow the resident back into the infested room until the protocol is fully completed.)
-Wipe down mattress, box spring, headboard, rails, dresser, nightstand and any other furniture, clean off any dead bed bugs, spray and powder and place bed bug resistant covers on the

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mattresses.
-Spray the room with bed bug insecticide and oil-based bed bug solution before putting the furniture back in the room. Put holes at the base and ceiling of the walls and spray the interior of the walls (If Needed).
-Re-inspect the room 24 hours after bed bug protocol is completed for any signs of further infestation.
-Document all findings!
-Continue with routine spraying schedule on Monday and Fridays.

Review of the facility's bed bug protocol notebook revealed:
-Each room that had activity or complaints of bed bugs were cleaned, the walls were wiped down, the outlets were inspected, and bed bug powder was put in the outlets.
-The furniture and clothing in the room were put in the "hot box" (a metal and tin box located on the outside premises of the facility that treats bed bug infected linens and items by heating the items for 3 to 4 hours.) for three to four hours. Everything was taken out of the room and sprayed down with a surface disinfectant spray.
-The rooms were sprayed down with a surface disinfectant spray, the chairs and headboards were pressure washed and cleaned with soap, then put back in the "hot box" to dry.
-Each resident room that had a complaint or activity of bed bugs was inspected by personal care aides (PCAs) and given a shower even if no bed bugs were found on residents.
-The last recorded bed bug sighting and inspection was dated September of 2019.
-There was no re-inspection documentation of rooms within 24 hours.
-The routine spraying schedule from Monday to Friday was not documented.

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D 079	Continued From page 3 1. Observation of resident room #212 on 02/19/20 at 11:35 am revealed: -The first bed was near the door in resident room #212 had multiple shoes underneath the bed beside the wall against the base boards. . -The second bed was near the window in resident room #212 had two live bed bugs on the pillow and one live bed bug was on the blanket. Interview with one of the residents in resident room #212 on 02/19/20 at 11:35 a.m. revealed: -She was bitten by bed bugs every night and she told the owner. -Maintenance sprayed in her room, but the bed bugs were still there. -Due to the bed bugs she did not sleep on her sheets. She slept on her blankets on top of her bed. -The bed bugs came from behind the base boards. She placed her shoes beside the base boards to keep the bed bugs inside the wall. -The bed bugs came from the roommates' bed to hers. -She did not inform the medication aides she was bitten, and she has not been treated for bed bugs bites. -She reported no visible signs of bed bug marks at this time. Refer to interview with the Maintenance worker on 02/19/20 at 12:01 pm. Refer to interview with the Maintenance worker on 02/21/20 at 2:39 pm. Refer to interview with the Resident Care Director on 02/21/20 at 6:11 pm. 2. Observation of resident room #212 on 02/19/20	D 079		

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at 12:03 p.m. revealed:
-The maintenance staff entered residents room #212 and removed the linens from the second bed near the window.
-The linens were placed in a black trash bag and placed in the "hot box".
-The maintenance staff sprayed the bed with a surface disinfectant spray.

Attempted interview with the second resident who resided in resident room #212 on February 19-21, 2020 was unsuccessful because she was out with family.

Observation of the second bed in resident room #212 on 02/21/20 at 2:41 p.m. revealed:
-The bed was removed from the wall.
-Three adult sized dead bed bugs were on the top blanket of the bed saturated with the disinfectant spray.

Interview with the Maintenance staff on 02/21/20 at 2:39 p.m. revealed:
-Bed bugs were found in room 212 again.
-The first time bed bugs were found in resident room #212 was 02/19/20.
-The second resident who resided in resident room #212 was not at the facility currently.
-The second resident who resided in resident room #212 accumulated a lot of items and if she would reduce the number of items in her room the bed bugs could be eliminated.
-He sprayed the room with the surface disinfectant spray and a product that inhibited bed bug reproduction to kill the adult bed bugs and eggs.
-The product that inhibited bed bug reproduction was currently used by the facility to kill bed bug eggs.
-The surface disinfectant spray was

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recommended by environmental services.
-The surface disinfectant spray was an intermediate level disinfectant which was effective against viruses, bacteria, and fungi.
-The product that inhibited bed bug reproduction was an insect growth regulator and juveniles that were exposed to it became unable to reproduce as adults. It was effective at inhibiting the reproduction cycle of bed bugs.
-He did not remove the clothing on 02/19/20 because he believed the bugs were coming from the dresser.
-He removed the clothing on 02/21/20 and placed them in the "hot box" for treatment.

3. Observation on 02/20/20 at 9:31 a.m. revealed:
-The resident who resided in resident room #117 had multiple red marks on his left bicep.
-He also had multiple red dots on his stomach area.

Observation of one of the beds in resident resident room #117 on 02/20/20 at 9:32 am revealed two live bed bugs were attached to the bed linens and one live bed bug ran across the bottom sheet of the bed.

Interview with one of the residents in resident room #117 on 02/20/20 at 9:28 a.m. revealed:
-Bed bugs were in his bed last night.
-The bed bugs bit him on his arm and stomach.
-His arm and chest were itching last night and this morning.

Refer to interview with the Maintenance worker on 02/19/20 at 12:01 pm.

Refer to interview with the Maintenance worker on 02/21/20 at 2:39 pm.

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D 079	Continued From page 6 Refer to interview with the Resident Care Director on 02/21/20 at 6:11 pm. 4. Interview with the second resident who resided in resident room #117 on 02/20/20 at 10:07 a.m. revealed he was not aware of bed bugs in the room. Refer to interview with the Maintenance worker on 02/19/20 at 12:01 pm. Refer to interview with the Maintenance worker on 02/21/20 at 2:39 pm. Refer to interview with the Resident Care Director on 02/21/20 at 6:11 pm. 5. Interview with the resident who resided in resident room #311 on 02/20/20 at 10:09 a.m. revealed: -A couple of weeks ago he pulled his night stand out from the wall and "twenty bed bugs" came from behind the stand. -The maintenance staff sprayed the room and killed most of the bugs. -During that incident, he was bitten by a bed bug, but he has no current bed bug bites. -Last night he noticed a bed bug crawling on his blanket. -He killed the bed bug and he believed he got the last one. Refer to interview with the Maintenance worker on 02/19/20 at 12:01 pm. Refer to interview with the Maintenance worker on 02/21/20 at 2:39 pm. Refer to interview with the Resident Care Director on 02/21/20 at 6:11 pm.	D 079		

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D 079	Continued From page 7 Interview with the Maintenance staff on 02/19/20 at 12:01 p.m. revealed: -Staff from another shift reported to him and the Administrator about seeing bed bugs "last week". -The maintenance staff and owner went to the facility on 02/15/20 and checked the facility for bed bugs but did not find bed bugs. -There were no complaints from residents regarding bed bugs. Interview with the Maintenance staff on 02/21/20 at 2:39 p.m. revealed: -The linen was taken off the beds where bed bugs were found and placed in a black trash bag and taken to the hot box on 02/19/20 and 02/21/20. -The mattresses were sprayed with the surface disinfectant spray along with the perimeter of the room. A substance that inhibited bed bug reproduction was also applied to the room. -The bed bug situation was "under control" and no complaints had been received from residents. He did not have an answer on how the bed bugs were entering the building. -Maintenance was not responsible for what residents bring in the facility or checking items when residents were admitted. -The facility had a bed bug protocol book, but he must update it. Interview with the Resident Care Director (RCD) on 02/21/20 at 6:11 p.m. revealed: -Aides checked the rooms "every day" for bed bugs when they make the beds. -The maintenance staff sprayed every week for bed bugs and as needed. -She had no knowledge of why there were no documented checks for bed bugs in the bed bug protocol notebook.	D 079		

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D 079	Continued From page 8 -Bed bugs were not her "department" and she had no knowledge of the pest control company that came to the building or what they treated. -Aides have been educated on the bed bug protocol. -The owner dealt with issues regarding bed bugs and the pest control company, and complaints about bugs go to the maintenance man. -Additional surface disinfectant spray was ordered last week by the business manager. -The owner also purchased a new pesticide to kill the eggs. -She did not have the knowledge to answer bed bug questions. -She did not have additional answers regarding policy and procedures for bed bugs, admission of resident's items, housekeeping, or how rooms are treated for bugs. _____ The facility failed to assure the resident rooms were clean and free of hazards as evidenced by the presence of bed bugs in the resident rooms #117, #212, and #311. The facility's failure to follow their established bed bug protocol resulted in residents having to live in an environment with bed bugs. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/19/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 3, 2020.	D 079		

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D 276	Continued From page 9	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure physician ordered fingerstick blood sugars (FSBS) were implemented for 1 of 3 sampled residents (#5). The findings are: Review of Resident #5's current FL-2 dated 12/30/19 revealed: -Diagnoses included Type 2 diabetes mellitus, hypertension, chronic kidney disease, acute cystitis, and neuromuscular dysfunction of bladder. -There was an order for Humalog insulin 100 units (U) /ml (used to treat diabetes mellitus) sliding scale as follows: 200 -250 = 2 units, 251-300= 4 units, 301 - 350 = 6 units, 351 - 400 = 8 units, and for blood sugar above 400 call the physician.	D 276		

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D 276	Continued From page 10 -There was no order for fingerstick blood sugars (FSBS). Review of Resident #5 's six-month physician orders revealed: -There was an order dated 01/10/20 to check and record blood sugar before meals and at bedtime. -There was an order for check and record blood sugars before meals and at bedtime and inject Humalog 100u/ml per sliding scale: 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351 - 400 = 8 units, call the physician for blood sugars above 400. Review of Resident #5's care plan dated 01/09/20 revealed she required FSBS four times per day. Review of Resident #5's Resident Register revealed an admission date of 01/03/20 from a rehabilitation facility. Review of Resident #5's Licensed Health Professional support (LHPS) initial evaluation dated 01/22/2020 revealed Resident #5' FSBS were four times daily. Review of Resident #5's January 2020 electronic medication administration record (eMAR) revealed: -There was an entry to check and record blood sugar before meals and at bedtime, scheduled for 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm. -There was documentation of FSBS on 01/03/2020 at 8:00 pm and at 4:00 pm there was documentation of staff initials only without a FSBS. -There was documentation of FSBS from 01/04/20 to 01/31/20 at 8:00 am, 12:00 pm, 4:00 pm and 8:00 pm. -The FSBS results ranged from 71 to 393.	D 276		

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D 276	Continued From page 11 Review of Resident #5 February 2020 eMAR revealed: -There was an entry to check and record blood sugar before meals and at bedtime, scheduled for 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm. -There was documentation of FSBS from 02/01/20 to 02/18/20 at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm. -There was documentation of FSBS on 02/19/20 at 8:00 am. -The FSBS results ranged from 71 to 351. Review of Resident #5's laboratory test drawn on 01/23/20 revealed the glycated hemoglobin (HgbA1C is a laboratory test that measures the average blood sugar concentrations for the preceding two to three months.) result was 7.1. Observation of Resident #5's glucometer on 02/21/20 at 3:25 pm revealed: -There was a green plastic storage container with Resident #5's name on it in the medication cart. -The green plastic storage container contained a black case with the glucometer and glucometer strips inside of it. -The black case and the glucometer did not have Resident #5's name on it. Review of Resident #5's glucometer readings for January 2020 on 02/21/20 at 3:26 pm revealed: -There were two glucometer readings for 01/04/20 at 12:30 pm and 9:10 pm and there were no readings at 8:00 am and 4:00 pm. -There was one glucometer reading for 01/05/20 at 1:40 pm of 104 and there were no readings at 8:00 am, 4:00 pm, and 8:00 pm. -There were two glucometer readings for 01/06/20 at 4:22 pm and 9:12 pm and there were no readings for 8:00 am, and 12:00 pm.	D 276		

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D 276	Continued From page 12 -There were three glucometer readings for 01/07/20 at 12:34 pm, 4:10 pm and 7:50 pm and there was no reading for 8:00 am. -There were two glucometer readings for 01/08/20 at 4:29 pm and 7:11 pm and there were no readings for 8:00 am and 12:00 pm. -There were three glucometer readings for 01/09/20 at 3:44 am, 12:16 pm, and 5:18 pm and there was one missing reading for 8:00 pm. -There were two glucometer readings for 01/10/20 at 5:52 pm and 9:59 pm and there were no readings for 8:00 am and 12:00 pm. -There were eight glucometer readings for 01/11/20, but there was no reading for 8:00 am and 12:00 pm. -There were three glucometer readings for 01/12/20 at 5:20 am, 5:21 am, and 7:21 pm and there were two missing reading for 12:00 pm and 4:00 pm. -There were two glucometer readings for 01/13/20 at 4:36 pm and 8:18 pm and there were no readings for 8:00 am and 12:00 pm. -There were two glucometer readings for 01/14/20 at 4:15 pm and 9:02 pm and there were no reading for 8:00 am and 12:00 pm. -There were three glucometer readings for 01/15/20 at 6:45 am, 3:43 pm, and 8:07 pm and there was one missing reading for 12:00 pm. -There were three glucometer readings for 01/16/20 at 5:33 am, 5:42 pm, and 8:29 pm and there was one missing reading for 12:00 pm. -There were three glucometer readings for 01/17/20 at 5:36 am, 4:30 pm, and 8:50 pm and there was one missing reading for 12:00 pm. -There were three glucometer readings for 01/18/20 at 5:41 am, 12:30 pm, and 4:38 pm and there was one missing reading for 8:00 pm. -There were two glucometer readings for 01/20/20 at 12:11 pm and 3:57 pm and there were no readings for 8:00 am and 8:00 pm.	D 276		

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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
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-There were three glucometer readings for 01/21/20 at 5:42 am, 5:37 pm, and 10:14 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 01/22/20 at 5:36 am, 5:05 pm, and 10:04 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 01/25/20 at 5:49 am, 4:17 pm, and 7:25 pm and there was one missing reading for 12:00 pm.
-There were two glucometer readings for 01/26/20 at 3:29 pm and 7:11 pm and there were no readings for 8:00 am and 12:00 pm.
-There were three glucometer readings for 01/27/20 at 12:12 pm, 4:03 pm and 9:04 pm and there was no reading for 8:00 am.
-There were three glucometer readings for 01/29/20 at 5:38 am, 1:31 pm, and 8:16 pm and there was one missing reading for 4:00 pm.
-There were three glucometer readings for 01/30/20 at 5:45 am, 3:49 pm, and 9:57 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 01/31/20 at 5:41 am, 4:47 pm, and 10:21 pm and there was one missing reading for 12:00 pm.
-There were 36 missing glucometer readings and 44 glucometer readings that did not match Resident #5's January 2020 FSBS documentation.

Review of Resident #5's glucometer readings for February 2020 on 02/21/20 at 3:26 pm revealed:
-There were two glucometer readings for 02/03/20 at 4:29 pm and 9:40 pm and there were two missing readings for 8:00 am and 12:00 pm.
-There were three glucometer readings for 02/04/20 at 5:33 am, 4:57 pm, and 9:38 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 02/05/20 at 5:53 am, 7:07 pm, and 9:47 pm and there were two missing readings for 12:00 pm

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and 4:00 pm.
-There were three glucometer readings for 02/06/20 at 5:51 am, 5:05 pm, and 7:14 pm and there was one missing reading for 12:00 pm.
-There were two glucometer readings for 02/09/20 at 3:47 pm and 7:51 pm and there were two missing readings for 8:00 am and 12:00 pm.
-There were three glucometer readings for 02/13/20 at 6:35 am, 4:30 pm, and 8:18 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 02/14/20 at 5:23 am, 4:16 pm, and 8:44 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 02/15/20 at 1:09 pm, 4:44 pm and 7:38 pm and there was no reading for 8:00 am.
-There were three glucometer readings for 02/16/20 at 12:31 pm, 4:43 pm and 7:08 pm and there was no reading for 8:00 am.
-There were three glucometer readings for 02/17/20 at 11:45 am, 5:03 pm and 7:50 pm and there was no reading for 8:00 am.
-There were three glucometer readings for 02/20/20 at 5:33 am, 12:12 pm and 7:41 pm and there was no reading for 4:00 pm.
-There were 14 missing glucometer readings for Resident #5 and 11 readings that did not match Resident #5's February MAR FSBS documentation.

Interview with Resident #5 on 02/21/20 at 3:00 pm revealed staff did her FSBS two times daily and sometimes three times.

Interview with Resident #5's physician on 02/21/20 at 4:41 pm revealed:
-She ordered FSBS for Resident #5 four times a day because of the sliding scale insulin.
-Staff needed to obtain FSBS results in order to administer the sliding scale insulin.

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D 276	Continued From page 15 -She reviewed Resident #5's FSBS results on the MARs. -She had not been told by staff of any difficulty related to obtaining Resident #5's FSBS. Interview with a first shift medication aide (MA) on 02/21/20 at 1:39 pm revealed: -She obtained Resident #5's FSBS in the morning and before lunch. -She did not know why Resident #5's documented FSBS results were not in Resident #5's glucometer. -She referred to residents' MARS when obtaining FSBS and obtained them before meals. -She documented the FSBS result after obtaining it. -No one reviewed the MARs or FSBS results. -If there were any problems with the glucometers or documentation of the FSBS she would tell the Resident Care Director (RCD) or the Administrator. -She did not know of a policy related to obtaining FSBS. Telephone interview with a second and third shift MA on 02/21/20 at 6:09 pm revealed: -She was familiar with Resident #5 and obtained Resident #5's FSBS at night and sometimes in the morning before first shift arrived. -She placed all the residents' plastic storage containers on the top of the medication cart with the lids opened and reached in to use the glucometers stored in unlabeled black cases. -The plastic storage containers were labeled with residents' names -The black cases and the glucometers did not have resident names on them. -She often found the few glucometers with residents' names on them in the wrong plastic storage container.	D 276		

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-She worked primarily on the weekend and every weekend she inventoried the glucometers, placing the labeled glucometers in the correct plastic storage containers.
-She may have grabbed the wrong black case and used the wrong glucometer because all of the plastic storage containers were opened when she did residents' FSBS.
-There was a lot of activity related to residents when she obtained FSBS and she may have been distracted.
-She saw other MAs obtaining Resident #5's FSBS but she did not know why the documentation did not match Resident #5's glucometer.
-She thought Resident #5's FSBS were done four times per day but that some of the FSBS results were in another resident's glucometer.

Attempted telephone interviews with a first shift MA on 02/21/20 at 11:15 am and 5:45 pm was unsuccessful.

Interview with a second shift MA on 02/21/20 at 6:03 pm revealed:
-She did Resident #5's FSBS and she did not know why the glucometer showed the FSBS not done four times a day.
-Staff received training from a pharmacy representative in January 2020 on medication administration and diabetic care.

Interview with the RCD on 02/21/20 at 5:02 pm revealed:
-She expected MAs to follow the physician orders when obtaining FSBS.
-She reviewed some of Resident #5's glucometer readings on 02/21/20 and she saw that Resident #5's readings were done twice daily or three times daily in January 2020 and February 2020.

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D 276	Continued From page 17 -She was not previously aware that Resident #5's FSBS was not obtained four times a day. -She thought it was done four times a day and the only way to prove it would be to look at each residents' glucometer to find the documented FSBS result in someone else's glucometer. -She knew the physician used Resident #5's documented FSBS when caring for the resident because she saw the physician reviewing the documented FSBS using the eMAR system. -She had provided new glucometers, training for staff in January 2020 on medication administration and diabetic care and spoke to them concerning following physician orders. -She expected staff to obtain Resident #5's FSBS four times a day as ordered and she was responsible for ensuring MAs implemented this order for Resident #5.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure air vents on an air conditioner unit, ice machine filter and the blades on a portable fan were clean and free of contamination related to a thick layer of dusty air blowing over stored dishes and the food preparation area. The findings are:	D 282		

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D 282	Continued From page 18 Observation of the kitchen area near the dish washer on 02/21/20 at 2:15 pm revealed there was an air conditioner unit, and it was blowing dusty air over stored dishes in a dish rack. Interview with the Dietary Manager (DM) on 02/21/19 at 2:15 pm revealed: -He did not know that the air vents on an air conditioner unit were blowing dusty air over the stored dishes in the kitchen. -The housekeeping staff were responsible for cleaning the air vents on the air conditioner unit in the kitchen area. -The air vents on the air conditioner unit in the kitchen were cleaned about 2 months ago. Observation of the kitchen area near the air conditioner unit on 02/21/20 at 2:17 pm revealed: -The DM used a cloth to wipe the dust from the air vents on the air conditioner unit. -The dust fell on the dishes stored in the dish rack. -He removed the dishes and dish rack away from the air conditioner unit. Observation of the ice machine on 02/21/20 at 2:35 pm revealed the air filter was dusty. Observation of a portable fan sitting on the serving door in the kitchen on 02/21/20 at 2:45 pm revealed: -The fan blades were dusty. -The fan was blowing dusty air into the food preparation and stored dishes area in the kitchen. Interview with the DM on 02/21/20 at 2:45 pm revealed: -He would rewashed the plates stored in the dish rack	D 282		

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D 282	Continued From page 19 -The air filter on the ice machine was cleaned on 02/20/20. -The air filter on the ice machine should be cleaned weekly. -He did not know who was responsible for setting the portable fan on the kitchen serving door. -He did not know how long the fan had been sitting on the kitchen serving door. -He did not know who was responsible for cleaning the blades on the portable fan. -He would turn the fan off and remove it from the serving door in the kitchen. Interview with the Resident Care Director (RCD) on 02/21/20 at 4:00 pm revealed: -She was not responsible for supervising the DM. -The Supervisor of the DM was not available for interview. -The kitchen staff were responsible for cleaning the air vents on the air conditioner unit, not the housekeeping staff. -She would notify the DM that the dietary staff were responsible for cleaning the air vents on the air conditioner unit not the housekeeping staff. -The air filter on the ice machine should be cleaned weekly by the kitchen staff. -There was a weekly cleaning schedule, and the DM was responsible for following the weekly cleaning schedule. -The DM was responsible for scheduling a dietary staff to do weekly cleaning in the kitchen which included cleaning of the blades of the fan if used in the kitchen area.	D 282		
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	D 283		

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D 283	Continued From page 20 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 and interviews, the facility failed to ensure food was prepared or stored in a manner to prevent contamination as evidenced by preparing and storing food adjacent to multipurpose and disinfectant cleansers, an unclean meat drain, a ladder with paint spots, mop and pressure washer. The findings are: Observation of the meat preparation area on 02/21/20 at 2:55 pm revealed: -There were 4 bottles of disinfectants and 2 bottles of multipurpose cleansers setting on the floor near the meat preparation area. -There was a built up of black substances around the meat drain container. -Spaghetti and black substances were lying on the meat drain. Observation of the kitchen area on 02/21/20 at 3:00 pm revealed: -There was a pressure washer in a shopping cart setting near the meat preparation area. -There was also a 4-foot ladder which was speckled with paint sitting near the stored dishes in a dish rack. -There was also a dry mop lying on the last step of the ladder. Interview with the Dietary Manager (DM) on 02/21/20 at 3:00 pm revealed: -He cleaned the meat drain in December 2019.	D 283		

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D 283	Continued From page 21 -The spaghetti was served for the lunch meal on 02/20/20. -There was no specified time to clean the meat drain. -Housekeeping staff stored the 2 multipurpose and 4 disinfectant cleansers in the kitchen area. -He was not sure how long the multipurpose and disinfectant cleansers had been stored in the kitchen area. -The ladder, mop and pressure washer had been left in the kitchen area by the maintenance staff. -He was not sure how long the ladder, mop and pressure washer had been stored in the kitchen area. Interview with the Resident Care Director (RCD) on 02/21/20 at 4:00 pm revealed: -She was not responsible for supervising the DM. -The Supervisor of the DM was not available for interview. -She did not know 2 multipurpose and 4 disinfectant cleansers were stored in the kitchen on the floor near the meat preparation area. -The cleansers should not have been stored on the floor in the kitchen. -She was not sure how often the meat drain should be cleaned. -She had no idea about the ladder or pressure washer being stored in the kitchen area.	D 283		
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	D 358		

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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 medications as ordered for 2 of 3 sampled residents receiving a long acting insulin (Resident #3) and a rapid acting insulin (Residents #3 and #5).

The findings are:

1. Review of Resident #3's current FL2 dated 01/31/20 revealed diagnoses included type II diabetes mellitus and schizophrenia.

a. Review of Resident #3's current FL2 dated 01/31/20 and previous signed physician orders dated 11/01/19 revealed:
-There was an order to check and record fingerstick blood sugar (FSBS) before meals and at bedtime. If FSBS less than 70 give orange juice and snack, recheck FSBS in 15 minutes after snack, if still less than 70 call doctor (MD). Call MD if FSBS greater than 500.
-There was an order for Novolog insulin (a rapid acting insulin used to lower blood sugar levels) 12 units three times a day. Hold for FSBS less than 110 or if patient does not eat.

Review of Resident #3's December 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check and record fingerstick blood sugar (FSBS) before meals and at bedtime. If FSBS less than 70 give orange juice and snack, recheck FSBS in 15 minutes after snack, if still less than 70 call doctor (MD).

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D 358	Continued From page 23 Call MD if FSBS greater than 500 scheduled for 6:00am, 12:00pm, 5:00pm, and 8:00pm daily. -There was an entry for Novolog insulin 12 units three times a day. Hold for FSBS less than 110 or if patient does not eat. -There was documentation for FSBS checks for 124 of 124 opportunities. -There were 13 FSBS values documented below 110 with documentation Novolog insulin was administered 3 times when it should have been held: On 12/09/19 at 6:00am, FSBS was 97 and 12 units of Novolog was administered at 8:00am (the next FSBS documented on 12/09/19 at 12:00pm was 276); On 12/15/19 at 12:00pm, FSBS was 103 and 12 units of Novolog was administered at 12:00pm (the next FSBS documented on 12/15/19 at 5:00pm was 93); and on 12/31/19 at 6:00am, FSBS was 76 and 12 units of Novolog was administered at 8:00am (the next FSBS documented on 12/31/19 at 12:00pm was 368). -There were 4 FSBS values documented greater than 110 when Novolog insulin was documented as not administered with no documentation for why the resident did not receive 12 units of Novolog insulin as ordered: On 12/09/19 at 5:00pm, FSBS was 116 and Novolog insulin was documented as not administered; On 12/12/19 at 5:00pm, FSBS was 112 and Novolog insulin was documented as not administered; On 12/13/19 at 5:00pm, FSBS was 155 and Novolog insulin was documented as not administered; and on 12/30/19 at 5:00pm, FSBS was 115 and Novolog insulin was documented as not administered. Review of Resident #3's January 2020 eMAR revealed: -There was an entry for check and record fingerstick blood sugar (FSBS) before meals and at bedtime. If FSBS less than 70 give orange	D 358		

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juice and snack, recheck FSBS in 15 minutes after snack, if still less than 70 call doctor (MD). Call MD if FSBS greater than 500 scheduled for 6:00am, 12:00pm, 5:00pm, and 8:00pm daily.
-There was an entry for Novolog insulin 12 units three times a day. Hold for FSBS less than 110 or if patient does not eat.
-There was documentation for FSBS checks for 121 of 124 opportunities.
-There were 12 FSBS values documented below 110 with documentation Novolog insulin was administered 2 times when it should have been held; on 01/03/20 at 6:00am FSBS was 88 and 12 units of Novolog was administered at 8:00am (the next FSBS documented on 01/03/20 at 12:00pm was 193), and on 01/17/20 at 12:00pm FSBS was 65 and 12 units of Novolog was administered at 12:00pm (the next FSBS documented on 01/17/20 at 5:00pm was 224).
-There were 4 FSBS values documented greater than 110 when Novolog insulin was documented as not administered with no documentation for why the resident did not receive 12 units of Novolog insulin as ordered: On 01/06/20 at 5:00pm, FSBS was 141 and Novolog insulin was documented as not administered with no documentation why; on 01/07/20 at 6:00am, FSBS was 122 and Novolog insulin was documented as not administered with no documentation why; On 01/09/20 at 5:00pm, FSBS was 126 and Novolog insulin was documented as not administered with no documentation why; and on 01/10/20 at 5:00pm, FSBS was 119 and Novolog insulin was documented as not administered with no documentation why.

Review of Resident #3's February 2020 eMAR revealed:
-There was an entry for check and record

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fingerstick blood sugar (FSBS) before meals and at bedtime. If FSBS less than 70 give orange juice and snack, recheck FSBS in 15 minutes after snack, if still less than 70 call doctor (MD). Call MD if FSBS greater than 500 scheduled for 6:00am, 12:00pm, 5:00pm, and 8:00pm daily.
-There was an entry for Novolog insulin 12 units three times a day. Hold for FSBS less than 110 or if patient does not eat.
-There was documentation for FSBS checks for 68 of 72 opportunities from 02/01/20 to 02/18/20.
-There were 7 FSBS values documented below 110 with documentation Novolog insulin was administered 2 times when it should have been held; on 02/04/20 at 12:00pm FSBS was 83 and 12 units of Novolog was administered at 12:00pm (the next FSBS documented on 02/04/20 at 5:00pm was 161), and on 02/11/20 at 6:00am FSBS was 93 and 12 units of Novolog was administered at 8:00am (the next FSBS documented on 02/11/20 at 12:00pm was 204).
-There were 6 FSBS values documented greater than 110 when Novolog insulin was documented as not administered with no documentation for why the resident did not receive 12 units of Novolog insulin as ordered: On 02/03/20 at 12:00pm, FSBS was 122 and Novolog insulin was documented as not administered with no documentation why; On 02/09/20 at 5:00pm, FSBS was 115 and Novolog insulin was documented as not administered with no documentation why; On 02/10/20 at 5:00pm, FSBS was 154 and Novolog insulin was documented as not administered with no documentation why; On 02/13/20 at 5:00pm, FSBS was 112 and Novolog insulin was documented as not administered with no documentation why; On 02/15/20 at 5:00pm, FSBS was 113 and Novolog insulin was documented as not administered with no

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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 26 documentation why: and On 02/17/20 at 5:00pm, FSBS was 131 and Novolog insulin was documented as not administered with no documentation why. Interview with a second shift medication aide (MA) on 02/21/20 at 1:30pm revealed: -She knew Resident #3 had an order to hold Novolog insulin if the FSBS was less than 110 when checked before meals. -There were occasions in December 2019, January 2020, and February 2020 when she did not administer Novolog insulin to Resident #3 even though the FSBS was greater than 110. -She was not "comfortable administering Novolog to Resident #3 if the FSBS was less than 120 to 130 because the resident might have an episode of low blood sugar especially if he was having a day when his behaviors was rude or boisterous". It was hard to know if he would get in the dining room and then refuse to eat his meal. -She had not informed the Resident Care Director (RCD) that she did not administer Resident #3's Novolog insulin according to the orders because she knew the resident and he had "bottomed out" (experienced a low blood sugar) in the past and she did not want that to happen with her. Interview with another second shift MA on 02/21/20 at 3:20pm revealed: -Resident #3 refused Novolog insulin sometimes. -She administers Novolog insulin if the FSBS is over 110. -There were instances in December 2019, January 2020, and February 2020 when the eMAR documentation indicated that she did not administer Novolog insulin to Resident #3; but she was sure she administered Novolog: -She did not know why the documentation was missing on the eMAR.	D 358		

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-Perhaps Novolog insulin was documented as not administered because the eMAR documentation option for administering insulin in the stomach was located adjacent to the documentation for "no site needed" and maybe she tapped on the wrong line of the touch screen.

Interview with the Resident Care Director (RCD) on 02/21/20 revealed:
-She was responsible for ensuring medication staff administered medications as ordered.
-Within the last month, she had discussed the importance of staff documenting correctly the amount of insulin and the site of insulin subsequent to the contracted consultant Pharmacist's last visit when it was pointed out that some staff may be incorrectly documenting insulin administration.
-She audited eMARs for completed documentation at least weekly.
-There was no system in place to routinely audit FSBS values documented on the eMAR compared to insulin administration, including site of administration.
-She did not know Resident #3's Novolog was not administered as ordered.

Interview with the facility's contracted Nurse Practitioner (NP) on 02/21/20 at 3:45pm revealed:
-She did not know Resident #3's Novolog was not administered as ordered for several occasions in December 2019, January 2020, and February 2020.
-She routinely looked at Resident #3's eMAR when she saw the resident for routine medications checks or sick calls.
-She looked more for documentation holes on the eMARs than documentation for medication not administered.
-She wanted staff to administer Novolog insulin

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according to the parameters if the blood sugar was greater than 110 because the resident's FSBS had been 300 to high 400 values in the past.
-Only if staff knew the resident was not going to eat should Novolog insulin be held.

Telephone interview with a third shift medication aide (MA) on 02/21/20 at 6:30pm revealed:
-She worked the night shift (11:00pm to 7:00am), evening shift (3:00pm to 11:00pm), and morning shift (7:00am to 3:00pm) when needed by the facility.
-She administered insulin to Resident #3 during some of the shifts she worked.
-She knew Resident #3 had an order to hold Novolog insulin if the FSBS was lower than 110.
-She was "not comfortable administering insulin to Resident #3 if his FSBS was less than 120".
-She had not administered Novolog insulin at times when Resident #3's FSBS was between 110 and 120 or if the resident was having "bad behaviors" and might refuse to eat.
-There was no where she documented holding Novolog insulin if she thought the resident was not going to eat.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

2. Review of Resident #3's current FL2 dated 1/31/20 and signed physician orders dated 11/01/19 revealed:
-There was an order to check and record fingerstick blood sugar (FSBS) before meals and at bedtime. If FSBS less than 70 give orange juice and snack, recheck FSBS in 15 minutes after snack, if still less than 70 call doctor (MD). Call MD if FSBS greater than 500.

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D 358	Continued From page 29 -There was an order for Novolog insulin (a rapid acting insulin used to lower blood sugar levels) 12 units three times a day. Hold for FSBS less than 110 or if patient does not eat.). -There was an order for Levemir (A long acting insulin used to lower blood sugar levels) twice a day. There was no order for parameters to hold administration of Levemir. Review of Resident #3's December 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check and record FSBS before meals and at bedtime, scheduled for administration at 6:00am, 12:00pm, 5:00pm, and 8:00pm daily. -There was an entry for Levemir insulin inject 32 units twice a day scheduled for administration at 9:00am and 9:00pm daily. -Levemir insulin was documented as administered 55 of 62 opportunities. -Levemir was documented as not administered by using "no site needed" for 7 opportunities as follows: On 12/03/19 at 9:00pm (on 12/9/19 at 8:00pm the FSBS was 138), on 12/09/19 at 9:00pm (on 12/09/19 at 8:00pm the FSBS was 131), on 12/10/19 at 9:00pm (on 12/10/19 at 8:00pm the FSBS was 130), on 12/18/19 at 9:00pm (on 12/18/19 at 8:00pm the FSBS was 70), on 12/22/19 at 9:00am (on 12/22/19 at 6:00am the FSBS was 112), on 12/25/19 at 9:00pm (on 12/25/19 at 8:00pm the FSBS was 78), and on 12/28/19 at 9:00pm (on 12/28/19 at 8:00pm the FSBS was 116). Review of Resident #3's January 2020 eMAR revealed: -There was an entry for Levemir insulin inject 32 units twice a day scheduled for administration at 9:00am and 9:00pm daily.	D 358		

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-Levemir insulin was documented as administered 60 of 62 opportunities.
-Levemir was documented as not administered by using "no site needed" for 6 opportunities as follows: On 01/07/20 at 9:00am (on 01/07/20 at 6:00am the FSBS was 122) and at 9:00pm (on 01/07/20 at 8:00pm the FSBS was 137); on 01/09/20 at 9:00pm (on 01/09/20 at 8:00pm the FSBS was 142); on 01/16/20 at 9:00pm (on 01/16/20 at 8:00pm the FSBS was 129); on 01/23/20 at 9:00pm (on 01/23/20 at 8:00pm the FSBS was 169); and on 01/28/20 at 9:00pm (on 01/28/20 at 8:00pm the FSBS was 117.

Review of Resident #3's February 2020 eMAR revealed:
-There was an entry for Levemir insulin inject 32 units twice a day scheduled for administration at 9:00am and 9:00pm daily.
-Levemir insulin was documented as administered 28 of 36 opportunities.
-Levemir was documented as refused 4 times at 9:00pm from 02/01/20 to 02/18/20 (on 02/05/20, 02/09/20, 02/11/20, and 02/14/20).
-Levemir was documented as not administered by using "no site needed" for 5 opportunities as follows: On 02/04/20 at 9:00pm (on 02/04/20 at 8:00pm the FSBS was 148); on 02/05/20 at 9:00pm (on 02/05/20 at 8:00pm the FSBS was refused); on 02/06/20 at 9:00pm (on 02/06/20 at 8:00pm the FSBS was 162); on 02/07/20 at 9:00pm (on 02/07/20 at 8:00pm the FSBS was 169); and on 02/18/20 at 8:00am (on 012/18/20 at 6:00am the FSBS was refused).

Interview with a second shift medication aide (MA) on 02/21/20 at 1:30pm revealed:
-There were occasions in December 2019, January 2020, and February 2020 when she did not administer Levemir insulin to Resident #3.

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-She was not comfortable administering Levemir to Resident #3 if the FSBS check was less than 120 to 130 because the resident might have an episode of low blood sugar.
-She had not informed the Resident Care Director (RCD) that she did not administer Resident #3's Levemir insulin according to the orders because she knew the resident and he had experienced a low blood sugar in the past when he received Levemir at night and she did not want that to happen with her.

Interview with another second shift MA on 02/21/20 at 3:20pm revealed:
-Resident #3 did not have an order to hold Levemir insulin if the FSBS was below any value.
-There were instances in December 2019, January 2020, and February 2020 were the eMAR documentation was that she did not administer Levemir insulin to Resident #3 because if the FSBS was close to 100 she was not comfortable with giving any insulin, even a long acting insulin.
-She did not inform the RCD she was not administering Levemir to Resident #3 if the FSBS was below 120.

Interview with the facility's contracted Nurse Practitioner (NP) on 02/21/20 at 3:45pm revealed:
-She did not know Resident #3's Levemir was not administered as ordered for several occasions in December 2019, January 2020, and February 2020.
-She routinely looked at Resident #3's eMAR when she saw the resident for routine medication checks or sick calls.
-She looked more for documentation holes on the eMARs than documentation for medication not administered.
-She wanted staff to administer Levemir insulin as

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ordered because the resident's FSBS values routinely were more than 200 throughout most of the day.

Interview with the Resident Care Director (RCD) on 02/21/20 revealed:
-She was responsible for ensuring medication staff administered medications as ordered.
-She audited eMARs for completed documentation routinely (at least weekly).
-There was no system in place to routinely audit FSBS values documented on the eMAR compared to insulin administration, including site of administration.
-She did not know Resident #3's Levemir insulin was not administered as ordered.

Telephone interview with a third shift medication aide (MA) on 02/21/20 at 6:30pm revealed:
-She worked the night shift (11:00pm to 7:00am), evening shift (3:00pm to 11:00pm), and morning shift (7:00am to 3:00pm) when needed by the facility.
-She administered insulin to Resident #3 during some of the shifts she worked.
-She knew Levemir was a long acting insulin and did not cause rapid drops in blood sugar.
-She was not comfortable administering Levemir insulin to Resident #3 if his FSBS was less than 120.
-She had not administered Levemir insulin at times when Resident #3's FSBS was between 110 and 120.
-She had not discussed holding Levemir insulin with the Resident Care Director (RCD) or Administrator.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

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D 358	Continued From page 33 3. Review of Resident #5's current FL-2 dated 12/30/19 revealed: -Diagnoses included type 2 diabetes mellitus, hypertension, chronic kidney disease, acute cystitis, and neuromuscular dysfunction of bladder. -There was an order for Humalog insulin 100 units (U) /ml (used to treat diabetes mellitus) sliding scale as follows: 200 -250 = 2 units, 251-300= 4 units, 301 - 350 = 6 units, 351 - 400 = 8 units, and for blood sugar above 400 call the physician. Review of Resident #5 's six-month physician orders revealed: -There was an order dated 01/10/20 to check and record blood sugar before meals and at bedtime. -There was an order for check and record blood sugars before meals and at bedtime and inject Humalog 100u/ml per sliding scale: 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351 - 400 = 8 units, call the physician for blood sugars above 400. Review of Resident #5's Resident Register revealed an admission date of 01/03/20 from a rehabilitation facility. Review of Resident #5's January 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog Kwikpen injection 100U/ml check blood sugars before meals and at bedtime and inject Humalog per sliding scale insulin: 200 - 250 = 2 units, 251- 300 = 4 units, 301 - 350 = 6 units, 351 - 400 = 8 units, above 400 call the physician, scheduled at 8:00 am, 12:00 pm , 4:00 pm, and 8:00 pm. -There were spaces for site, blood sugar and	D 358		

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amount given under the scheduled time of administration.
-There was documentation of FSBS, the amount of Humalog insulin administered per the sliding scale or refusals from 01/04/20 to 01/31/20 at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm.
-There were 44 documented FSBS that were not found in Resident #5's glucometer.

Review of Resident #5's glucometer readings for January 2020 revealed:
-There were two glucometer readings for 01/04/20 at 12:30 pm and 9:10 pm and there were no readings at 8:00 am and 4:00 pm.
-There was one glucometer reading for 01/05/20 at 1:40 pm of 104 and there were no readings at 8:00 am, 4:00 pm, and 8:00 pm.
-There were two glucometer readings for 01/06/20 at 4:22 pm and 9:12 pm and there were no readings for 8:00 am, and 12:00 pm.
-There were three glucometer readings for 01/07/20 at 12:34 pm, 4:10 pm and 7:50 pm and there was no reading for 8:00 am.
-There were two glucometer readings for 01/08/20 at 4:29 pm and 7:11 pm and there were no readings for 8:00 am and 12:00 pm.
-There were three glucometer readings for 01/09/20 at 3:44 am, 12:16 pm, and 5:18 pm and there was one missing reading for 8:00 pm.
-There were two glucometer readings for 01/10/20 at 5:52 pm and 9:59 pm and there were no readings for 8:00 am and 12:00 pm.
-There were eight glucometer readings for 01/11/20, but there was no reading for 8:00 am and 12:00 pm.
-There were three glucometer readings for 01/12/20 at 5:20 am, 5:21 am, and 7:21 pm and there were two missing reading for 12:00 pm and 4:00 pm.
-There were two glucometer readings for

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01/13/20 at 4:36 pm and 8:18 pm and there were no readings for 8:00 am and 12:00 pm.
-There were two glucometer readings for 01/14/20 at 4:15 pm and 9:02 pm and there were no reading for 8:00 am and 12:00 pm.
-There were three glucometer readings for 01/15/20 at 6:45 am, 3:43 pm, and 8:07 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 01/16/20 at 5:33 am, 5:42 pm, and 8:29 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 01/17/20 at 5:36 am, 4:30 pm, and 8:50 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 01/18/20 at 5:41 am, 12:30 pm, and 4:38 pm and there was one missing reading for 8:00 pm.
-There were two glucometer readings for 01/20/20 at 12:11 pm and 3:57 pm and there were no readings for 8:00 am and 8:00 pm.
-There were three glucometer readings for 01/21/20 at 5:42 am, 5:37 pm, and 10:14 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 01/22/20 at 5:36 am, 5:05 pm, and 10:04 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 01/25/20 at 5:49 am, 4:17 pm, and 7:25 pm and there was one missing reading for 12:00 pm.
-There were two glucometer readings for 01/26/20 at 3:29 pm and 7:11 pm and there were no readings for 8:00 am and 12:00 pm.
-There were three glucometer readings for 01/27/20 at 12:12 pm, 4:03 pm and 9:04 pm and there was no reading for 8:00 am.
-There were three glucometer readings for 01/29/20 at 5:38 am, 1:31 pm, and 8:16 pm and there was one missing reading for 4:00 pm.
-There were three glucometer readings for 01/30/20 at 5:45 am, 3:49 pm, and 9:57 pm and

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there was one missing reading for 12:00 pm.
-There were three glucometer readings for 01/31/20 at 5:41 am, 4:47 pm, and 10:21 pm and there was one missing reading for 12:00 pm.
-There were 36 missing glucometer readings and 44 glucometer readings that did not match Resident #5's January 2020 FSBS documentation.
-There were two glucometer readings for 01/04/20 at 12:30 pm and 9:10 pm and there were no readings at 8:00 am and 4:00 pm.
-There was one glucometer reading for 01/05/20 at 1:40 pm of 104 and there were no readings at 8:00 am, 4:00 pm, and 8:00 pm.
-There were two glucometer readings for 01/06/20 at 4:22 pm and 9:12 pm and there were no readings for 8:00 am, and 12:00 pm.
-There were three glucometer readings for 01/07/20 at 12:34 pm, 4:10 pm and 7:50 pm and there was no reading for 8:00 am.
-There were two glucometer readings for 01/08/20 at 4:29 pm and 7:11 pm and there were no readings for 8:00 am and 12:00 pm.
-There were three glucometer readings for 01/09/20 at 3:44 am, 12:16 pm, and 5:18 pm and there was one missing reading for 8:00 pm.
-There were two glucometer readings for 01/10/20 at 5:52 pm and 9:59 pm and there were no readings for 8:00 am and 12:00 pm.
-There were eight glucometer readings for 01/11/20, but there was no reading for 8:00 am and 12:00 pm.
-There were three glucometer readings for 01/12/20 at 5:20 am, 5:21 am, and 7:21 pm and there were two missing reading for 12:00 pm and 4:00 pm.
-There were two glucometer readings for 01/13/20 at 4:36 pm and 8:18 pm and there were no readings for 8:00 am and 12:00 pm.
-There were two glucometer readings for

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CRESCENT GREEN OF CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 37 01/14/20 at 4:15 pm and 9:02 pm and there were no reading for 8:00 am and 12:00 pm. -There were three glucometer readings for 01/15/20 at 6:45 am, 3:43 pm, and 8:07 pm and there was one missing reading for 12:00 pm. -There were three glucometer readings for 01/16/20 at 5:33 am, 5:42 pm, and 8:29 pm and there was one missing reading for 12:00 pm. -There were three glucometer readings for 01/17/20 at 5:36 am, 4:30 pm, and 8:50 pm and there was one missing reading for 12:00 pm. -There were three glucometer readings for 01/18/20 at 5:41 am, 12:30 pm, and 4:38 pm and there was one missing reading for 8:00 pm. -There were two glucometer readings for 01/20/20 at 12:11 pm and 3:57 pm and there were no readings for 8:00 am and 8:00 pm. -There were three glucometer readings for 01/21/20 at 5:42 am, 5:37 pm, and 10:14 pm and there was one missing reading for 12:00 pm. -There were three glucometer readings for 01/22/20 at 5:36 am, 5:05 pm, and 10:04 pm and there was one missing reading for 12:00 pm. -There were three glucometer readings for 01/25/20 at 5:49 am, 4:17 pm, and 7:25 pm and there was one missing reading for 12:00 pm. -There were two glucometer readings for 01/26/20 at 3:29 pm and 7:11 pm and there were no readings for 8:00 am and 12:00 pm. -There were three glucometer readings for 01/27/20 at 12:12 pm, 4:03 pm and 9:04 pm and there was no reading for 8:00 am. -There were three glucometer readings for 01/29/20 at 5:38 am, 1:31 pm, and 8:16 pm and there was one missing reading for 4:00 pm. -There were three glucometer readings for 01/30/20 at 5:45 am, 3:49 pm, and 9:57 pm and there was one missing reading for 12:00 pm. -There were three glucometer readings for 01/31/20 at 5:41 am, 4:47 pm, and 10:21 pm and	D 358		

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there was one missing reading for 12:00 pm.
-There were 36 missing glucometer readings and 44 glucometer readings that did not match Resident #5's January 2020 MAR FSBS documentation.

Review of Resident #5 February 2020 eMAR revealed:
-There was an entry for Humalog Kwikpen injection 100U/ml check blood sugars before meals and at bedtime and inject Humalog per sliding scale insulin: 200 - 250 = 2 units, 251- 300 = 4 units, 301 - 350 = 6 units, 351 - 400 = 8 units, above 400 call the physician, scheduled at 8:00 am, 12:00 pm , 4:00 pm, and 8:00 pm.
-There were spaces for site, blood sugar and amount given under the scheduled time of administration.
-There was documentation of FSBS, the amount of Humalog insulin administered per the sliding scale or refusals from 02/01/20 to 02/18/20 at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm.
-There were 11 documented FSBS that were not found in Resident #5's glucometer.

Review of Resident #5's glucometer readings for February 2020 revealed:
-There were two glucometer readings for 02/03/20 at 4:29 pm and 9:40 pm and there were two missing readings for 8:00 am and 12:00 pm.
-There were three glucometer readings for 02/04/20 at 5:33 am, 4:57 pm, and 9:38 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 02/05/20 at 5:53 am, 7:07 pm, and 9:47 pm and there were two missing readings for 12:00 pm and 4:00 pm.
-There were three glucometer readings for 02/06/20 at 5:51 am, 5:05 pm, and 7:14 pm and there was one missing reading for 12:00 pm.

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-There were two glucometer readings for 02/09/20 at 3:47 pm and 7:51 pm and there were two missing readings for 8:00 am and 12:00 pm.
-There were three glucometer readings for 02/13/20 at 6:35 am, 4:30 pm, and 8:18 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 02/14/20 at 5:23 am, 4:16 pm, and 8:44 pm and there was one missing reading for 12:00 pm.
-There were three glucometer readings for 02/15/20 at 1:09 pm, 4:44 pm and 7:38 pm and there was no reading for 8:00 am.
-There were three glucometer readings for 02/16/20 at 12:31 pm, 4:43 pm and 7:08 pm and there was no reading for 8:00 am.
-There were three glucometer readings for 02/17/20 at 11:45 am, 5:03 pm and 7:50 pm and there was no reading for 8:00 am.
-There were three glucometer readings for 02/20/20 at 5:33 am, 12:12 pm and 7:41 pm and there was no reading for 4:00 pm.
-There were 14 missing glucometer readings for Resident #5 and 11 readings that did not match Resident #5's February MAR FSBS documentation.

Observation of Resident #5's medication on hand on 02/20/20 at 10:40 am revealed there was one Humalog Kwikpen dispensed on 01/03/20 and labeled opened on 02/10/20.

Interview with a pharmacist at the facility contracted pharmacy on 02/20/20 at 12:49 pm revealed one Humalog Kwikpen was dispensed for Resident #5 on 01/03/20 and again on 01/13/20 with the facility's cycle fill.

Interview with Resident #5's physician on 02/21/20 at 4:41 pm revealed:
-Resident #5 was admitted in January 2020 and

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she was admitted with a wound to manage.
-She last saw Resident #5 on 02/07/20.
-Resident #5 had sliding scale insulin and a long acting insulin ordered.
-Resident #5's sliding scale insulin was ordered for four times a day to better manage her diagnosis of diabetes mellitus.
-Because of the wound, her age, and history of diabetes it was important to maintain her HgBA1C below 8.
-Resident #5's most recent HgBA1C was 7.1 drawn in January 2020.
-She expected staff to administer sliding scale insulin to Resident #5 as ordered.

Interview with a first shift medication aide (MA) on 02/21/20 at 1:39 pm revealed:
-She administered Humalog sliding scale insulin to Resident #5 based on Resident #5's FSBS results.
-Resident #5's FSBS results were usually below 200 and she did not require the sliding scale insulin.
-She did not know why Resident #5's FSBS results documented on the eMAR were not found in Resident #5's glucometer.
-She did not know if there was a medication administration policy.

Attempted telephone interview with another first shift MA on 02/21/20 at 11:15 am and 5:45 pm was unsuccessful.

Interview with a second and third shift MA on 02/21/20 at 5:49 pm revealed:
-She obtained some of the FSBS on third shift for the first shift MA and documented the results in the eMAR system.
-She did not administer the sliding scale insulin for the first shift MA because the resident would

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not be fed within 30 minutes.
-If the documented FSBS results did not match Resident #5's glucometer she did not receive the correct amount of sliding scale insulin.
-If the FSBS was not obtained there was no way to administer the correct amount of sliding scale insulin.

Telephone interview with another second and third shift MA on 02/21/20 at 6:09 pm revealed:
-The amount of sliding scale insulin Resident #5 was administered was dependent on her FSBS results.
-She may have grabbed the wrong glucometer when obtaining Resident #5's FSBS, and this was the reason for missing results or FSBS results that did not match Resident #5's glucometer.
-Resident #5 received the correct amount of sliding scale insulin but there was no documentation.
-Resident #5 did not require her sliding scale insulin because her blood sugars were low enough to not require the sliding scale insulin.

Interview with the Resident Care Director (RCD) on 02/21/20 at 5:02 pm revealed:
-She expected MAs to administer sliding scale insulin according to the physician's orders.
-She did not know Resident #5's glucometer readings did not match Resident #5's documented FSBS results on the eMAR.
-She thought Resident #5 was administered the correct dose of sliding scale insulin but to prove it she would have to review each diabetic resident's glucometer to find the documented FSBS on the eMAR.
-She was responsible for residents receiving the correct dose of sliding scale insulin.
-She was responsible for ensuring the MAs administered the correct dose of sliding scale

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D 358	Continued From page 42 insulin. -She did not audit the MARs or FSBS results. Based on observations, record reviews and interviews there were 55 values that did not correspond with Resident #5's glucometer so it could not be determined if the correct amount of sliding scale insulin was administered.	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 and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to housekeeping and furnishings to include hazards, and Adult Care Home infection prevention guidelines. The findings are: 1. Based on observations, record review, and interviews, the facility failed to assure the facility was clean and free of hazards as evidenced by the presence of bedbug activity in resident rooms #117, #212, and #311. [Refer to Tag D0079, 10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings (Type B Violation)].	D912		

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D912	Continued From page 43 2.Based on observation, record reviews, and interviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 4 of 5 sampled residents (#4, #5, #13, and #15) with diabetes, resulting in sharing glucometers between residents. [Refer to Tag D932, G.S. 131D-4.4 A (b) ACH Infection Prevention Requirements (Type B Violation)].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a	D932		

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D932	Continued From page 44 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 observation, record reviews, and interviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 4 of 5 sampled residents (#4, #5, #13, and #15) with diabetes, resulting in sharing glucometers between residents.	D932		

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D932	Continued From page 45 The findings are: Observation of fingerstick blood sugar (FSBS) testing by a morning medication aide (MA) on 02/20/20 at 12:05pm revealed: -The MA donned gloves, removed a plastic storage case containing a zipper pouch with a Brand A glucometer (a blood glucose monitoring device). The plastic container, zippered pouch, and glucometer were labeled with the same name matching the resident identified for FSBS testing. -The MA used proper infection prevention techniques to obtain the FSBS. -The MA used an alcohol wipe to wipe the outside of the glucometer prior to placing the glucometer back in the labeled zipper pouch. -The MA disposed of the single use lancing device and test strip in a biohazard waste container and the gloves and alcohol swabs in the trash. Review of the CDC guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instruction. If the manufacturer does not list disinfecting information, then the glucometer should not be shared between residents. Review of manufacturer's user guide for Brand A glucometer revealed: -The user guide did not contain instructions for disinfecting the glucometer. -There were cleaning instructions as follows: clean the outside of the glucometer with a damp cloth and mild soap or detergent. Keep the test port from getting wet.	D932		

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D932	Continued From page 46 -Use a dry tissue or alcohol swab to clean the test strip port. Observation of the facility's medication carts and residents' glucometers on 02/21/20 at 3:45pm revealed: -There were 3 medication carts containing resident's glucometers. -The medication cart for the 300 Hall had 7 plastic containers labeled with residents' names and containing a Brand A glucometer. -The medication cart for the 100 Hall had 5 plastic containers labeled with resident's names and containing a Brand A glucometer. Observation of the facility on 02/19/20 at 8:50 am revealed there was a Clinical Laboratory Improvement Amendments (CLIA) certificate hanging on the wall near the front lobby area that expires on 03/03/2021. 1. Observation of Resident #5's glucometer on 02/21/20 at 3:17 pm revealed: -There was a green plastic storage container with Resident #5's name on it in the medication cart. -The green plastic storage container contained a black case with the glucometer and glucometer strips inside of it. -The black case and the glucometer did not have Resident #5's name on it. Review of Resident #5's Brand A glucometer readings for January 2020 revealed: -On 01/11/20 at 5:02 pm, there was a FSBS of 287 with no corresponding FSBS value documented on the electronic medication administration record (eMAR). -On 01/11/20 at 5:30 pm, there was a FSBS of 221 with no corresponding FSBS value documented on the eMAR.	D932		

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D932	Continued From page 47 -On 01/11/20 at 5:31 pm, there was a FSBS of 54 with no corresponding FSBS value documented on the eMAR. -On 01/11/20 at 8:05 pm, there was a FSBS of 99 with no corresponding FSBS value documented on the eMAR. -On 01/11/20 at 8:23 pm, there was a FSBS of 201 with no corresponding FSBS value documented on the eMAR. -On 01/11/20 at 8:28 pm, there was a FSBS of 590 with no corresponding FSBS value documented on the eMAR. -On 01/12/20 there was a FSBS at 5:20 am of 113 with no corresponding FSBS value documented on the eMAR, -On 01/12/20 at 5:21 am, there was a FSBS of 121 which corresponded to the FSBS value documented on the eMAR. -On 01/12/20 at 7:21 pm, there was a FSBS of 227 with no corresponding FSBS value documented on the eMAR. -On 01/19/20 at 4:37 pm there was a FSBS of 156 with no corresponding FSBS value documented on the eMAR. -On 01/19/20 at 4:44 pm there was a FSBS of 160 with no corresponding FSBS value documented on the eMAR. Review of Resident #5's Brand A glucometer readings for February 2020 revealed: -On 02/01/20 at 6:22 am, there was a FSBS of 145 with no corresponding FSBS value documented on the eMAR. -On 02/01/20 at 4:33 pm, there was a FSBS of 153 with a corresponding FSBS value documented on the eMAR. -On 02/01/20 at 4:35 pm, there was a FSBS of 164 with no corresponding FSBS value documented on the eMAR. -On 02/01/20 at 4:39 pm, there was a FSBS of	D932		

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D932	Continued From page 48 143 with no corresponding FSBS value documented on the eMAR. -On 02/01/20 at 7:56 pm, there was a FSBS of 199 with a corresponding FSBS value documented on the eMAR. -On 02/01/20 at 8:36 pm, there was a FSBS of 208 with no corresponding FSBS value documented on the eMAR. -On 02/02/20 at 12:10 pm, there was a FSBS of 109 with a corresponding FSBS value documented on the eMAR. -On 02/02/20 at 4:52 pm, there was a FSBS of 119 with a corresponding FSBS value documented on the eMAR. -On 02/02/20 at 4:56 pm, there was a FSBS of 229 with no corresponding FSBS value documented on the eMAR. -On 02/02/20 at 7:15 pm, there was a FSBS of 156 with a corresponding FSBS value documented on the eMAR. -On 02/08/20 at 7:06 pm, there was a FSBS of 272 with a corresponding FSBS value documented on the eMAR. -On 02/08/20 at 8:15 pm, there was a FSBS of 114 with no corresponding FSBS value documented on the eMAR. Interview with a second and third shift Medication Aide (MA) on 02/21/20 at 5:49 pm revealed: -She did not know Resident #5's glucometer had multiple FSBS readings within minutes of each other. -Resident #5 would not allow anyone to stick her multiple times. -She used glucometers located in a resident's labeled plastic storage container. -She had not seen a policy for glucometer use and she had completed the infection control training. -She used alcohol pads to clean residents'	D932		

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D932	Continued From page 49 glucometers. Telephone interview with another second and third shift MA on 02/21/20 at 6:09 pm revealed: -Resident #5 would not allow MAs to stick her finger within a minute of the last fingerstick. -She did not know Resident #5's glucometer held readings that were within minutes of the other on the same date. -If Resident #5's glucometer held readings that were within minutes of the other it might have been used for other residents. Interview with the Resident Care Director on 02/21/20 at 5:02 pm revealed: -She thought Resident #5 would not allow anyone to stick her multiple times. -There was no reason to check Resident #5's FSBS that many times in one day. -She thought Resident #5's glucometer was used for other residents. -She thought another resident's glucometer contained Resident #5's the FSBS documented on the eMAR that were not contained in Resident #5's glucometer. -She would have to review each diabetic residents' glucometer to locate those FSBS results. -She did not know Resident #5's glucometer was used for other residents' FSBS monitoring. Refer to telephone interview with another second and third shift MA on 02/21/20 at 6:09 pm. Refer to interview with the RCD on 02/21/20 at 5:02 pm. Refer to the telephone interview with the contracted Consultant Pharmacist on 02/21/20 at 5:05pm.	D932		

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	HAL068024	A. BUILDING: _____ B. WING _____	02/21/2020

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D932	Continued From page 50 2. Review of Resident #4's current FL-2 dated 10/18/19 revealed: -Diagnoses included dementia, insomnia, hypertension, constipation, diabetic neuropathy, gastroesophageal reflux disease (GERD), allergic rhinitis, cardiac disorder, major depressive disorder, hyperlipidemia, psychosis, cardiac failure and seizure. -There was an order for Novolog Flexpen inject 13 units subcutaneously three times daily with meals and hold blood glucose (BG) if less than 110 or patient does not eat. (Novolog is a fast acting insulin that helps to control blood sugar spikes that happen when you eat). -There was also an order for Novolog injection per sliding scale: 201-250 =3 units, 251-300 =5 units, 301-350=7 units, 351-400=9 units, 401-450=14 units and repeat in 1 hour if still more than 450 notify primary care physician (PCP). Review of Resident #4's signed physician order sheet dated 11/29/19 revealed: -There was an order for Novolog Flexpen to check and record blood sugar before meals and inject per sliding scale: 201-250 =3; 251-300 = 5 units, 301-350 =7 units, 351-400=9 units, 401-450=12 units if more than 450=14 units and repeat in 1 hour if more than 450 notify PCP. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Review of Resident #4's Brand A glucometer's history revealed: -The glucometer was labeled with the resident's name, stored in a zipper case labeled with the resident's name and located in a plastic box	D932		

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D932	Continued From page 51	D932		

labeled with the resident's name.
-The time and date were set correctly on the glucometer.
-The glucometer was working without any error messages.
-The glucometer readings were reviewed for a portion of February 2020.

Review of the fingerstick blood sugar (FSBS) values stored in the memory of the Brand A glucometer labeled for Resident #4 revealed there were multiple FSBS values within a short period of time and the FSBS values stored in the glucometer's memory that were inconsistent with values documented on the resident's electronic Medication Administration Record (eMAR) as follows:
-On 02/16/20 at 6:24am, there was a FSBS reading of 113 which corresponded to the FSBS value documented on the eMAR.
-On 02/16/20 at 6:25am, there was a FSBS reading of 362 with no FSBS value documented on the eMAR.
-On 02/16/20 at 6:32am, there was a FSBS reading of 155 with no FSBS value documented on the eMAR.
-On 02/15/20 at 5:48am, there was a FSBS reading of 86 with no FSBS value documented on the eMAR (documented on another resident's eMAR at the corresponding time with no matching FSBS value in that resident's glucometer's memory).
-On 02/15/20 at 5:49am, there was a FSBS reading of 238 with no FSBS value documented on the eMAR (documented on another resident's eMAR at the corresponding time with no matching FSBS value in that resident's glucometer's memory).
-On 02/15/20 at 5:58am, there was a FSBS reading of 116 with no FSBS value documented

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D932	Continued From page 52 on the eMAR. -On 02/15/20 at 6:00am, there was a FSBS reading of 270 with no FSBS value documented on the eMAR. -On 02/15/20 at 6:01am, there was a FSBS reading of 163 with no FSBS value documented on the eMAR. -On 02/15/20 at 6:09am, there was a FSBS reading of 193 which corresponded to the FSBS value documented on the eMAR for 6:00am on 02/15/20. -On 02/15/20 at 6:10am, there was a FSBS reading of 160 with no FSBS value documented on the eMAR. -On 02/15/20 at 6:18am, there was a FSBS reading of 179 with no FSBS value documented on the eMAR. -On 02/15/20 at 6:21am, there was a FSBS reading of 181 with no FSBS value documented on the eMAR. -On 02/15/20 at 6:30am, there was a FSBS reading of 134 with no FSBS value documented on the eMAR. -On 02/15/20 at 6:31am, there was a FSBS reading of 104 with no FSBS value documented on the eMAR. -On 02/15/20 at 6:32am, there was a FSBS reading of 140 with no FSBS value documented on the eMAR. Based on observations and record reviews there were two glucometer readings on Resident #4's Brand A glucometer that were documented on Resident #4's February 2020 eMAR on 02/16/20 at 6:24am of 113 and on 02/15/20 at 6:09am of 193. There were 11 additional FSBS values stored in the glucometer's memory on 02/15/20 from 5:48am to 6:32am and 2 additional FSBS values in the glucometer's memory on 02/16/20 from 6:24am to 6:32am.	D932		

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D932	Continued From page 53 Refer to telephone interview with another second and third shift MA on 02/21/20 at 6:09 pm. Refer to interview with the RCD on 02/21/20 at 5:02 pm. Refer to the telephone interview with the contracted Consultant Pharmacist on 02/21/20 at 5:05pm. 3. Review of Resident #15's current FL2 dated 07/20/19 revealed: -Diagnoses included diabetes mellitus type II. -There was an order to check fingerstick blood sugar (FSBS) twice a day. Review of Resident #15's physician's orders dated 11/08/19 revealed check and record FSBS twice daily was ordered. Review of the plastic container labeled with Resident #15's name and used to store a glucometer revealed: -There was zippered pouch labeled with Resident #15's name. -Inside the zippered pouch was a Brand A glucometer labeled with another resident's name. Review of the glucometer labeled with a different resident's name located in Resident #15's zippered pouch on 02/21/20 at 5:00pm compared to the resident's February 2020 electronic Medication Administration Record (eMAR) revealed: -Time and date were set correctly in the glucometer. -There were fingerstick blood sugar (FSBS) values documented twice a day from 02/17/20 to 02/20/20, from 02/07/20 to 02/14/20 matching	D932		

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D932	Continued From page 54 FSBS values in Resident #15's glucometer's memory. -There were FSBS values in the glucometer's memory on 02/03/20 at 12:24pm (285), on 02/05/20 at 10:15am (179) and at 1:21pm (187) when Resident #15 was documented for out of the facility on the resident's eMAR. Telephone interview on 02/21/20 at 6:30pm with a 3rd shift medication aide(MA) revealed: -The facility policy was to have a glucometer for each resident. -The were no disinfecting wipes in the facility as far as she knew. -There was no routine cleaning of the residents' glucometers, however she routinely cleaned the glucometers with alcohol wipes when she saw anything that look like blood on the glucometer. -She knew Resident #15's zippered glucometer pouch contained a glucometer for a resident that was no longer at the facility. She thought the glucometer had been switched when Resident #15's previous glucometer had stopped working. She noticed the change a few weeks ago but assumed the Resident Care Director had assigned Resident #15 the glucometer that belonged to a resident no longer at the facility. -She did not think the facility had replacement batteries for the glucometers. -She had not seen a staff member use a glucometer to check FSBS values on more than one resident. Refer to telephone interview with another second and third shift MA on 02/21/20 at 6:09 pm. Refer to interview with the RCD on 02/21/20 at 5:02 pm. Refer to the telephone interview with the	D932		

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D932	Continued From page 55 contracted Consultant Pharmacist on 02/21/20 at 5:05pm. 4. Review of Resident #13's current FL2 dated 01/03/20 revealed: -There was a diagnosis included diabetes mellitus II. -There was an order to check and record finger stick blood sugars (FSBS) before meals and at bedtime. Review of Resident #13's Brand A glucometer's memory on 02/21/20 at 2:21pm revealed: -The time and date were set correctly in the glucometer. -The glucometer was labeled with Resident #13's name. -The glucometer was stored in a zippered pouch labeled with Resident #13's name. -The zippered pouch was stored in a plastic container also labeled for Resident #13. Review of Resident #13's February 2020 electronic Medication Administration Record (eMAR) revealed: -Values recorded in the labeled glucometer's memory were consistent for values documented on the February 2020 eMAR from 02/13/20 to 02/20/20 except for 3 FSBS values documented on the eMAR but not located in the glucometer's memory. -On 02/15/20 at 6:00am there was a FSBS value of 238 documented on the eMAR but not stored in the glucometer's memory. -There was a FSBS value of 238 stored in the Resident #4's glucometer's memory at 5:49am with no corresponding value on Resident #4's eMAR for 02/15/20 at 5:49am. -There was a FSBS value of 156 on 02/17/20 at 5:42am and a FSBS value of 179 at 5:51 am on	D932		

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D932	Continued From page 56 02/16/20 documented on Resident #13's eMAR with no corresponding FSBS value recorded in Resident #13's glucometer's memory for either day. Refer to telephone interview with another second and third shift MA on 02/21/20 at 6:09 pm. Refer to interview with the RCD on 02/21/20 at 5:02 pm. Refer to the telephone interview with the contracted Consultant Pharmacist on 02/21/20 at 5:05pm. _____ Telephone interview with another second and third shift MA on 02/21/20 at 6:09 pm revealed: -When she obtained residents' FSBS, she placed all the residents' plastic storage containers opened on the top of the medication cart and reached in to use the glucometers stored in black cases. -The plastic storage containers were labeled with residents' names -The black cases and the glucometers did not have residents' names on them. -She often found the few glucometers with residents' names on them in the wrong plastic storage container. -She worked primarily on the weekend and every weekend she inventoried the glucometers placing the labeled glucometers in the correct plastic storage containers. -She may have grabbed the wrong black case and used the wrong glucometer because all of the plastic storage containers were opened when she did residents' FSBS. -She cleaned all the residents' glucometers on the weekend with alcohol pads.	D932		

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D932	Continued From page 57 Interview with the Resident Care Director on 02/21/20 at 5:02 pm revealed: -She expected MAs to use glucometers belonging to the resident whose name was labeled on the storage container. -She had provided new glucometers, training with a pharmacy representative, and she instructed them to not use the same glucometer between residents. -She thought that MAs were not using the correct glucometer for the correct resident if the documented FSBS did not match the glucometer readings. -There were no sanitizing wipes provided for cleaning the glucometers. -She was responsible for ensuring glucometers were not shared between residents. -She could not locate the policy for medication administration and FSBS on 02/20/20 and 02/21/20. -She did not review the eMARs or FSBS readings in anyway. Telephone interview with the contracted Consultant Pharmacist on 02/21/20 at 5:05pm revealed: -She had been completing the Quarterly Pharmacy Reviews for the facility since November 2019. -She did not routinely monitor or review residents' glucometers for labeling, accuracy of FSBS values in the glucometer's memories. -She looked at the eMARs of residents with FSBS checks ordered to determine if the eMARs were complete. _____ The failure of the facility to implement infection control procedures consistent with CDC guidelines resulted in at least 11 residents	D932		

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D932	Continued From page 58 receiving fingerstick blood sugar checks with the same glucometer. This failure exposed 11 diabetic residents with orders for blood glucose checks to increased risk of exposure to contracting blood borne pathogens diseases. This failure was detrimental to the health, safety and welfare of the diabetic residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/21/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 3, 2020.	D932		