STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
C 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted an annual survey and a follow-up survey on 05/05/21 and 05/06/21.	C 000		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to infection prevention requirements. The findings are: Based on observations, interviews, and record reviews, the facility failed to maintain infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines for infection prevention during blood sugar monitoring for 3 of 3 sampled residents (#1, #2, #3) with orders for fingerstick blood sugars (FSBS) resulting in glucometers being shared between residents. [Refer to Tag 932, G.S. 131D-4.4 A(b) Adult Care Home Infection Prevention Requirements (Type B Violation)].	C 912		
C 932	G.S. 131D 4.4A (b) ACH Infection Prevention Requirements	C 932		

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C 932	Continued From page 1 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the 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.	C 932		

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C 932	Continued From page 2 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to maintain infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines for infection prevention during blood sugar monitoring for 3 of 3 sampled residents (#1, #2, #3) with orders for fingerstick blood sugars (FSBS) resulting in glucometers being shared between residents. The findings are: Review of the CDC's recommended guidelines for infection transmission and prevention during blood glucose monitoring revealed: -"Whenever possible, blood glucose meters should be assigned to an individual person and not be shared." -If a glucometer was to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions after every use. If the manufacturer does not specify how the glucometer should be cleaned and disinfected, then it should not be shared. Observation of the facility's medication cart and residents' glucometers on 05/05/21 at 3:45pm revealed: -The medication cart was stored in the Supervisor-in Charge's (SIC) bedroom/office. -The medication cart had 1 unlabeled plastic storage bag containing a Brand A glucometer not labeled with a resident's name and a lancing pen labeled with a resident's name. -The medication cart had 2 unlabeled plastic storage bags; each bag containing a Brand B	C 932		

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C 932	Continued From page 3 glucometer labeled with a resident's name and a lancing pen labeled with the same resident's name. 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. -Use a dry tissue or alcohol swab to clean the test strip port. Telephone interview with a manufacturer's representative on 05/05/21 at 4:24pm revealed: -The Brand A glucometer was recommended for "single-patient use only". -The manufacturer did not recommend using the glucometer for more than a single patient and should not be shared. Review of the owner's manual for Brand B glucometer revealed: -The glucometer "is intended to be used by a single person". -The approved product for cleaning and disinfecting the meter (glucometer) is Super Sani-Cloth (Environmental Protection Agency approved). -A solution of Clorox and water mixed 1:10 can be used to clean the meter. Interview with the Owner/Administrator on 05/06/21 at 10:30am revealed there were no residents with a diagnosis of a bloodborne pathogen disease. Interview with the SIC on 05/05/21 at 4:30pm	C 932		

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C 932	Continued From page 4 revealed: -The unlabeled glucometer was assigned to one of the residents. -There were 3 residents with physician's orders to check FSBS. -She had been sharing the unlabeled glucometer to check 2 other residents' FSBS because their glucometers would not come on when the test strips were inserted. -She used the lancing pen assigned to each resident to prick their finger because she knew not to share. She did not share the lancing pens between residents. -She was advised by the Owner/Administrator on 05/03/21 that she could use the facility's disinfecting wipes to wipe down the glucometer between residents until the Owner/Administrator was able to replace or fix the residents' glucometers that were not working. 1. Review of Resident #1's current FL2 dated 03/23/21 revealed: -Diagnoses included diabetes. -There was an order to check FSBS twice a day. Review of the FSBS values stored in the history of the glucometer of an unlabeled Brand A glucometer (the only working glucometer on 05/05/21) identified by staff as Resident #1's glucometer revealed: -The date was set correct (05/05/21) and the time set in the glucometer was one hour behind the actual time (2:04pm displaying on glucometer and actual time 3:04pm). -There were 53 FSBS values documented from 05/05/21 at 7:04am to 04/23/21 at 6:01am (13 days) . -There were multiple FSBS values documented within a short period of time each morning and each afternoon.	C 932		

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C 932	Continued From page 5 Review of Resident #1's April 2021 Medication Administration Record (MAR) and "Blood Glucose monitoring" log compared to FSBS values stored in the history of the unlabeled Brand A glucometer for Resident #1's glucometer revealed examples as follows: -On 04/23/21, at 6:01am FSBS =163 corresponded to the FSBS value documented at 7:30am on the MAR for Resident #1; FSBS =96 at 5:22am and FSBS=126 at 5:21am were extra FSBS values in the glucometer's history not documented on Resident #1's MAR and corresponding to values documented on another resident's MAR on the same date. -On 04/26/21, at 6:15am FSBS =163 corresponded to the FSBS value documented at 7:30am on the MAR for Resident #1; FSBS =117 at 5:14am and FSBS=108 at 5:13am were extra FSBS values in the glucometer's history not documented on Resident #1's MAR and corresponding to values documented on another resident's MAR on the same date. -On 04/27/21, at 6:45am FSBS =140 corresponded to the FSBS value documented at 7:30am on the MAR for Resident #1; FSBS =109 at 5:34am and FSBS=152 at 5:23am were extra FSBS values in the glucometer's history not documented on Resident #1's MAR and corresponding to values documented on another resident's MAR on the same date. -On 04/28/21, at 6:22am FSBS =165 corresponded to the FSBS value documented at 7:30am on the MAR for Resident #1; FSBS =118 at 6:07am and FSBS=102 at 6:06am were extra FSBS values in the glucometer's history not documented on Resident #1's MAR and corresponding to values documented on another resident's MAR on the same date.	C 932		

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C 932	Continued From page 6 Review of Resident #1's May 2021 MAR and "Blood Glucose monitoring" log compared to FSBS values stored in the history of the unlabeled Brand A glucometer for Resident #1 revealed examples as follows: -On 05/02/21, at 7:05am FSBS =134 corresponded to the FSBS value documented at 7:30am on the MAR for Resident #1; FSBS =104 at 6:55am and FSBS=110 at 6:10am were extra FSBS values in the glucometer's history not documented on Resident #1's MAR and corresponding to values documented on another resident's MAR on the same date. -On 05/04/21, at 6:42am FSBS =172 corresponded to the FSBS value documented at 7:30am on the MAR for Resident #1; FSBS =97 at 5:28am and FSBS=115 at 5:20am were extra FSBS values in the glucometer's history not documented on Resident #1's MAR and corresponding to values documented on another resident's MAR on the same date. -On 05/05/21, at 7:04am FSBS =167 corresponded to the FSBS value documented at 7:30am on the MAR for Resident #1; FSBS =98 at 6:01am and FSBS=111 at 5:40am were extra FSBS values in the glucometer's history not documented on Resident #1's MAR and corresponding to values documented on another resident's MAR on the same date. Based observation, interviews, and record reviews, it was determined Resident #1 was not interviewable. Refer to the interview with the Owner/Administrator on 05/06/21 at 11:25am. 2. Review of Resident #3's current FL2 dated 03/23/21 revealed: -Diagnoses included neuro-cognitive disorder,	C 932		

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C 932	Continued From page 7	C 932		

alcohol use, hypertension, and depression.
-There was an order to check fingerstick blood sugar (FSBS) in the morning before breakfast and notify the provider if FSBS is greater than 400 or less than 60.

Observation on 05/05/21 at 3:45pm of one unlabeled plastic storage bag containing a Brand B glucometer reavealed:
-The glucometer was labeled with Resident #3's name and there was a lancing pen labeled with the same resident's name.
-The glucometer was not functioning and would not turn on.

Review of the FSBS values stored in the history of the only functioning glucometer (the unlabled Brand A glucometer identified by staff as Resident #1's glucometer) revealed:
-There were multiple FSBS values documented within a short period of time each morning and each afternoon.
-Some of the FSBS values stored in the glucometer history corresponded to values documented on Resident #3's Medication Administration Record (MARs) and "Blood Glucose monitoring" logs.

Review of Resident #3's April 2021 MAR and "Blood Glucose monitoring" log compared to FSBS values stored in the history of the unlabeled Brand A glucometer for Resident #1 revealed FSBS values stored in the glucometer's history that corresponded to FSBS values documented on Resident #3's MAR with examples as follows:
-On 04/23/21, FSBS =96 at 5:22am corresponded to the FSBS value documented on Resident #3's MAR at 7:30am but was recorded in the glucometer history identified as Resident

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#1's glucometer and not documented on Resident #1's MAR.
-On 04/26/21, FSBS =108 at 5:13am corresponded to the FSBS value documented on Resident #3's MAR at 7:30am but was recorded in the glucometer history identified as Resident #1's glucometer and not documented on Resident #1's MAR.
-On 04/27/21, FSBS =109 at 5:34am corresponded to the FSBS value documented on Resident #3's MAR at 7:30am but was recorded in the glucometer history identified as Resident #1's glucometer and not documented on Resident #1's MAR.
-On 04/28/21, FSBS=102 at 6:06am corresponded to the FSBS value documented on Resident #3's MAR at 7:30am but was recorded in the glucometer history identified as Resident #1's glucometer and not documented on Resident #1's MAR.

Review of Resident #3's May 2021 MAR and "Blood Glucose monitoring" log compared to FSBS values stored in the history of the unlabeled Brand A glucometer for Resident #1 revealed FSBS values stored in the glucometer's history that corresponded to FSBS values documented on Resident #3's MAR with examples as follows:
-On 05/02/21, FSBS =104 at 6:55am corresponded to the FSBS value documented on Resident #3's MAR at 7:30am but was recorded in the glucometer history identified as Resident #1's glucometer and not documented on Resident #1's MAR.
-On 05/04/21, FSBS = 97 at 5:28am corresponded to the FSBS value documented on Resident #3's MAR at 7:30am but was recorded in the glucometer history identified as Resident #1's glucometer and not documented on Resident

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C 932	Continued From page 9 #1's MAR. -On 05/05/21, FSBS=111 at 5:40am corresponded to the FSBS value documented on Resident #3's MAR at 7:30am but was recorded in the glucometer history identified as Resident #1's glucometer and not documented on Resident #1's MAR. Interview with Resident #3 on 05/06/21 at 11:05am revealed: -The staff used a black glucometer (Brand B) for a while but used a red (Brand A) glucometer lately to check her FSBS. -She only had her FSBS checked once daily before she ate breakfast. Refer to the interview with the Owner/Administrator on 05/06/21 at 11:25am. 3. Review of Resident #2's current FL2 dated 03/23/21 revealed: -Diagnoses included schizophrenia, borderline intellectual disability, and diabetes. -There was an order for metformin (used to treat elevated blood sugar) 500mg 2 tablets twice a day. -There was an order for Januvia (used to treat elevated blood sugar) 100mg daily. -There was no order for fingerstick blood sugar (FSBS) checks on the FL2. Review of Resident #2's record revealed an order for diabetic testing supplies (glucometer, test strips, and lancing needles) for testing blood sugar dated 11/07/18. Telephone interview with Resident #2's Primary care Provider (PCP) on 05/05/21 at 3:24pm revealed Resident #2's FL2 should have an order for FSBS testing 3 times a week or more often if	C 932		

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needed, for monitoring blood sugars since the resident was on 2 medications for lowering blood sugar.

Observation on 05/05/21 at 3:45pm of one unlabeled plastic storage bag containing a Brand B glucometer labeled with Resident #2's name and a lancing pen labeled with the same resident's name revealed the glucometer was not functioning and would not turn on.

Review of the FSBS values stored in the history of the only functioning glucometer (the unlabled Brand A glucometer identified by staff as Resident #1's glucometer) revealed:
-There were multiple FSBS values documented within a short period of time each morning and each afternoon.
-Some of the FSBS values stored in the glucometer history corresponded to values documented on Resident #2's Medication Administration Record (MARs) and "Blood Glucose monitoring" logs.

Review of Resident #2's April 2021 Medication Administration Record (MAR) and "Blood Glucose monitoring" log compared to FSBS values stored in the history of the unlabeled Brand A glucometer for Resident #1 revealed FSBS values stored in the glucometer's history that corresponded to FSBS values documented on Resident #2's MAR with examples as follows:
-On 04/23/21, FSBS =126 at 5:21am corresponded to the FSBS value documented on Resident #2's MAR at 7:30am but was recorded in the glucometer history identified as Resident #1's glucometer and not documented on Resident #1's MAR.
-On 04/26/21, FSBS =117 at 5:14am corresponded to the FSBS value documented on

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C 932	Continued From page 11 Resident #2's MAR at 7:30am but was recorded in the glucometer hsitory identified as Resident #1's glucometer and not documented on Resident #1's MAR. -On 04/27/21, FSBS =152 at 5:23am corresponded to the FSBS value documented on Resident #2's MAR at 7:30am but was recorded in the glucometer history identified as Resident #1's glucometer and not documented on Resident #1's MAR. -On 04/28/21, FSBS=118 at 6:07am corresponded to the FSBS value documented on Resident #2's MAR at 7:30am but was recorded in the glucometer history identified as Resident #1's glucometer and not documented on Resident #1's MAR. Review of Resident #2's May 2021 MAR and "Blood Glucose monitoring" log compared to FSBS values stored in the history of the Resident #2's Brand A glucometer revealed examples as follows: -On 05/02/21, FSBS =110 at 6:10am corresponded to the FSBS value documented on Resident #2's MAR at 7:30am but was recorded in the glucometer history identified as Resident #1's glucometer and not documented on Resident #1's MAR. -On 05/05/21, FSBS=98 at 6:01am corresponded to the FSBS value documented on Resident #2's MAR at 7:30am but was recorded in the glucometer history identified as Resident #1's glucometer and not documented on Resident #1's MAR. Interview with Resident #2 on 05/06/21 at 11:12am revealed: -The staff used a red (Brand A) glucometer to check her FSBS now, but she used to have a black glucometer (Brand B) for a while.	C 932		

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C 932	Continued From page 12 -She only had her FSBS checked once daily before breakfast each day. Refer to the interview with the Owner/Administrator on 05/06/21 at 11:25am. _____ Interview with the Owner/Administrator on 05/06/21 at 11:25am revealed: -She thought the contracted pharmacy had provided a policy for glucometer use, however she was unable to locate the policy book at the facility. -There was no facility infection control policy available for review. -The facility policy orally presented to medication aide staff was that glucometers should not be routinely shared. -She was not aware there were 2 glucometers not working at the facility as far back as 04/23/21. -She was aware the glucometers were not working 4 or 5 days ago when she had instructed the SIC to use the disinfecting wipes at the facility to wipe Resident #1's glucometer and use it to check the other residents FSBS. -The Administrator was not aware the Brand B glucometers had batteries that could be replaced in an attempt to restore function for glucometers. _____ The facility failed to implement infection control procedures consistent with CDC guidelines placing residents receiving finger stick blood sugar checks with glucometers shared between residents at risk due to possible exposure of bloodborne pathogens diseases for Residents #2 and #3. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection accordance with G.S. 131D-34 on 05/05/21 for	C 932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092228	A. BUILDING: _____ B. WING _____	R 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVELTY HEALTHCARE SERVICES II	6704 SHANGHI DRIVE WILLOW SPRINGS, NC 27592

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C 932	Continued From page 13 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 20, 2021.	C 932		