Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034097	A. BUILDING: _____ B. WING _____	C 06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA CREEK ASSISTED LIVING	2560 WILLARD ROAD WINSTON SALEM, NC 27107

(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 and Complaint investigation from June 29, 2021 to June 30, 2021.	D 000	The community will ensure that food being maintained and served as per created by the menu. Temperature logs will maintained and kept in the kitchen. The ED will review weekly with the Dietary Manager for 4 weeks and then ongoing as needed. This will start on July 16th and end on Aug 6. If the food is plated and waiting to be served the food will be placed under the heat lamp or covered with a insulated lid.	
D 288	10A NCAC 13F .0904(b)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (3) Hot foods shall be served hot and cold foods shall be served cold. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure hot foods were maintained hot until residents were ready to eat their meals. The findings are: Observation of the kitchen during the lunch meal on 06/29/21 from 12:09pm to 1:15pm revealed: -Hot food was plated seven at a time and set uncovered on the top of the hot food service line at 12:09pm. -There was cold air from a vent in the ceiling blowing on the uncovered plates. -The first plates of food were served at 12:19pm. -At 12:22pm five of the seven plates were still setting on the shelf above the food service line. -Food was plated and set on the top of the hot food service line while staff served two plates at a time; three to four plates were setting on the food service line waiting to be served to residents. -At 12:25pm a second pan of food was removed from the top of a tilt skillet that was not on and placed in the hot food service line; the cook began to plate food from the second pan of food.	D 288	The ED or designee will observe a meal once weekly for the next four weeks to see if any residents have concerns. This will also be reviewed during resident council meetings monthly. This will start July 16th and end on Aug 6. The community will ensure that only one glucometer is used per each resident. The glucometers will be checked and matched to the MAR for the next 8 weeks and then as needed ongoing. This will start July 7th and end September 1st. Addendum 7/26/21 per Pate Wilkerson-The ED or designee will audit glucometer use and MARs weekly. [illegible] per Pate Wilkerson-The LHPS RN will provide staff inservices on an ongoing basis [illegible] The community will hold an in service with all medication aides and review infection control, diabetic training and glucometer training. Medication Aides will be revalidated on skills. Completion date by August 17th. Resident Rights will be reviewed and signed with employees on July 22nd. Addendum 7/26/21 per Pate Wilkerson-The DRC or ED will audit MARs to ensure accuracy of orders and administration of medications by medication aides every two weeks for four weeks and ongoing. Addendum 7/26/21 per Pate Wilkerson: -The ED or designee will audit glucometer use and MARs weekly. -The LHPS RN will provide staff inservices on an ongoing basis for new hires and current staff for infeciton control, diabetes and glucometer training. -The DRC or ED will audit MARs to ensure accuracy of orders and administation of medication by medication aides every two weeks for four weeks and ongoing.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pate Wilkerson Jr. TITLE: ED (X6) DATE: 7/27/21

STATE FORM 6899 BWR411 If continuation sheet 1 of 20

Received and accepted with addendums 07/26/21 Catherine Porter

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D 288	Continued From page 1 -There were 60 residents served in the dining room from 12:19pm to 1:01pm. -No temperatures were observed being taken of any food on the food service line. Observation of the food temperature log for the lunch meal for 06/29/21 revealed the entrée was documented at 138 degrees Fahrenheit and a side dish was documented at 150 degrees Fahrenheit; the Dietary Manager (DM) had corrected the entrée temperature by drawing a line through the first number and writing 183 degrees Fahrenheit beside it. Interview with a resident on 06/29/21 at 9:12am revealed: -The food had been cold recently. -She would have complained but she had complained in the past and the food was still cold so she "figured it would not do any good to complain anymore" Interview with a second resident on 06/29/21 at 10:20am revealed: -She lived at the facility for a year and a half and the food had been cold the entire time. -She told staff the food was cold, but staff did not say anything, and nothing was done to correct the temperature. Interview with six residents on 06/29/21 from 12:37pm to 1:10pm revealed: -The meal was warm but could be hotter. -One resident liked their food hotter. -Their meal was lukewarm, barely warm, room temperature or cold. -The food tasted good but it could be hotter. Interview with the evening cook on 06/30/21 at 2:22pm revealed:	D 288		

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D 288	Continued From page 2 -She only plated one plate of food at a time for the residents; as she plated the food the staff served the residents. -She served all the residents in the dining room in about fifteen minutes. -She took temperatures of the food when she placed it on the food service line. -She documented the temperatures of the food prior to service. -The food should be 145 to 160 degrees Fahrenheit for meal service. -She had not heard of residents complaining of food being cold. -If a resident complained their food was cold, she would heat food in the microwave. Interview with the Dietary Manager (DM) on 06/30/21 at 3:34pm revealed: -Food was placed in bulk pans on the hot food line no longer than 30 minutes prior to the meal service. -When there were two pans of a food item the second pan was kept in the oven on warm or placed on the top of the stove on low to maintain temperatures. -Temperatures of food was taken and documented on a log 10 to 15 minutes prior to each meal service; temperatures were not taken again during the meal service. -The food on the hot food service line was to be held at 141 degrees Fahrenheit or higher; when food was below 141 degrees Fahrenheit, she would reheat it to the desired temperature. -She did not have a system to warm the plates prior to meal service. -She had not been told residents were complaining about food being cold or not hot enough. -If a resident had complained of cold food, she would have served them a new plate of food.	D 288		

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D 288	Continued From page 3 -She did not plate multiple plates of food prior to the meal service; she did not set multiple plates of food on top of the food service line. -She would plate food and as soon as she set a plate on the top of the hot food service line the staff would serve the plate to the residents. -She had not thought about the cold air from the vent blowing on the food; the cool air could be cooling the food. Interview with the Administrator on 06/30/21 at 3:44pm revealed: -There had been a few complaints of cold food in the past, but it was a year ago. -He was not currently observing meal services in the dining room because there had not been any concerns from residents. -He was not aware the food was being placed on plates and then set on the top of the hot food service table for 10 to 15 minutes and had cool air blowing on them. -He thought the staff served the plated food to the residents as soon as it was plated by the cook. -He did not realize the kitchen staff did not keep the second pans of food in the oven to keep them hot. -The residents were welcome to speak to him at anytime and he was surprised by the complaint of cold food. -The residents could let the staff in the dining room know their food was not hot and the staff would reheat the plate or have a new plate of food made.	D 288		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367		

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D 367	Continued From page 4 record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the accuracy of the electronic medication administration records for 1 of 7 sampled residents related to medication used to lower cholesterol levels (#6) that was discontinued and continued to be administered. The findings are: Review of Resident #6's current FL-2 dated 01/14/21 revealed: -Diagnoses included COVID-19, acute cystitis with hematuria, muscle weakness, other abnormality of gait and mobility, lack of coordination, unsteadiness on feet, hypokalemia and obesity.	D 367		

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D 367	Continued From page 5 -There was an order for atorvastatin calcium (used to lower cholesterol levels) one tablet scheduled for the evening; no dosage amount was documented. Review of Resident #6's physician's orders dated 01/15/21 revealed an order for atorvastatin calcium (used to lower cholesterol levels) 80mg one tablet in the evening. Review of Resident #6's physician's orders dated 03/18/21 revealed Resident #6's atorvastatin 80mg was discontinued due to leg cramps and pain. Review of Resident #6's physician's order dated 03/20/21 revealed an order to discontinue atorvastatin. Review of Resident #6's electronic medication administration records (eMAR) for April 2021, May 2021 and June 2021 revealed there was no entry for atorvastatin. Review of Resident #6's medication on hand on 06/30/21 at 11:04am revealed: -Resident #6's medication was packaged in multidose bubble packs; each bubble was labeled with the scheduled administration time, date and day of the week; each bubble also listed the medications in the bubble. -Multiple medications were included in each bubble. -Resident #6 had a card that included two medications scheduled for evening administration in one bubble; one of the medications in the bubble was atorvastatin 80mg. -The next scheduled administration time on the bubble was Wednesday, 06/30/21 at 8:00pm; the bubble contained an atorvastatin tablet.	D 367		

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D 367	Continued From page 6 Interview with Resident #6 on 06/29/21 at 10:20am revealed: -She was not sure what medications she took. -She had complained of leg pain and twitching in her legs in January 2021 but her legs were not hurting anymore and were only twitching. Telephone interview with a Pharmacist from Resident #6's contracted pharmacy on 06/30/21 at 12:34pm revealed: -The pharmacy did not have a discontinue order for Resident #6's atorvastatin. -Atorvastatin 80mg administer one tablet in the evening was an active order. -The last three billing cycles 28 tablets were dispensed on 04/27/21, 28 tablets were dispensed on 05/25/21 and 22 tablets on 06/22/21. -Resident #6's atorvastatin was billed monthly but was dispensed in a multiple medication packages every seven days. -Each bubble on the medication card had multiple medications in the bubble. -The back of each bubble had the names of the medications included in the bubble, the administration time, date and day of the week. -The facility would notify the pharmacy of discontinued medications by faxing the discontinuation order to them. -The pharmacy would discontinue the medication and the facility was responsible for removing the medication from the eMAR. -One of the side effects of atorvastatin was leg cramps and leg pain. Telephone interview with Resident #6's primary care provider (PCP) on 06/30/21 at 3:00pm revealed: -She had discontinued Resident #6's atorvastatin	D 367		

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D 367	Continued From page 7 in March 2021 because Resident #6 complained of leg pain. -Resident #6 always complained of leg pain; she discontinued the atorvastatin to try to rule out reasons for the leg pain. -She expected the facility staff to follow through on her orders for residents' medications. Interview with a second shift medication aide (MA) on 06/30/21 at 4:13pm revealed: -Resident #6's atorvastatin had been discontinued for a little over a month; she could not recall how she knew it had been discontinued. -She did not administer Resident #6 the atorvastatin after it was discontinued. -She had "wasted" (disposed of) the atorvastatin every day since it had been discontinued. -She was supposed to document the disposal of all medication, but she had not documented the disposal of Resident #6's atrovastatin. -She did not know why she did not document the disposal of the atorvastatin; she "just did not do it". -She called the pharmacy once because they kept sending the atorvastatin and the pharmacy told her it had been discontinued. -She did not remember when she called, and she did not document the call. -She told the Resident Care Director (RCD) the atorvastatin for Resident #6 was still being sent by the pharmacy; she did not recall when she told the RCD. Interview with the RCD on 06/30/21 at 11:05pm revealed: -When a medication was discontinued by the PCP the order would be faxed to the pharmacy by the MA. -The MA would remove the discontinued medication from the eMAR.	D 367		

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D 367	Continued From page 8 -The fax machine was "messed up" during the month of March 2021. -She did not know Resident #6 had atorvastatin still available to administer since it had been discontinued. -She and the Resident Care Coordinator (RCC) and MAs audited medication carts and eMAR; they had not realized the atorvastatin was still being dispensed and on the medication cart. -She could not say if the atorvastatin had been administered to Resident #6; she could see where it may have been administered because it was in a bubble pack with multiple medications. -MAs were supposed to check the eMAR against the medication in the bubble package before administering the medication. -If there was a discontinued medication in the bubble then the MA should waste the medication and document the waste. -The atorvastatin had not been reported to her; the MAs should have told her or the RCC about the atorvastatin. -Staff should have notified her Resident #6's atorvastatin had been discontinued and that the pharmacy continued to dispense the atorvastatin. Interview with the RCC on 06/30/21 at 2:32pm revealed: -She sent discontinued medication orders to the pharmacy and when she was not at the facility the MAs sent discontinued medication orders to the pharmacy and would let her know. -Discontinued medication was removed from the eMAR at the facility by the MA. -When administering medication, the MAs were to compare the medication on the eMAR to the medication on the bubble package. -When there was a single discontinued medication in a multiple package the MA was supposed to waste the tablet and document the	D 367		

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D 367	Continued From page 9 waste. -There was no documentation Resident #6's atorvastatin had been wasted and the MAs had not notified her they had wasted any atorvastatin for the resident. -She did not know if Resident #6 had been administered the atorvastatin. -The medication carts were audited once a week by the MAs and once a week by the RCC. -The audit process was to count tablets and compare what was on the cart with the eMAR. -Staff had not discovered the discontinued atorvastatin on the medication cart during the audits. Interview with the Administrator on 06/30/21 at 3:06pm revealed: -The MAs should compare the medication in the bubble package to the eMAR before administering any medication, if there is a discrepancy, they should notify the RCC or the RCD. -The MAs should have alerted the RCC and the RCD that Resident #6 had a medication which was not on the eMAR but was dispensed by the pharmacy in a multiple dose package. -The RCC and the RCD were not aware Resident #6's atorvastatin had been discontinued and was still dispensed. -The MAs should have disposed of the atorvastatin when they opened the multiple packaged bubble. -The disposed medication should have been documented on a log when it was disposed of; he did not audit or check the log. -He could not say if the atorvastatin had been administered because it was not on the eMAR. -The MAs, the RCC and the RCD were responsible for conducting weekly and daily medication and eMAR audits.	D 367		

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D 367	Continued From page 10 -The eMAR was compared to the signed physician's orders and the medication on the cart was compared to the eMAR. -The discontinued atorvastatin was overlooked; he did not know what had happened.	D 367		
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, record reviews, 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 Adult Care Home infection prevention requirements. The findings are: Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 3 of 3 sampled diabetic residents (#5, #8 and #9) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. [Refer to Tag 932 G.S 131D-4.4A(b) Adult Care Home Infection Prevention Requirements (Type B Violation)].	D912		

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D932	Continued From page 11	D932		
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 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,	D932		

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D932	Continued From page 12 hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 3 of 3 sampled diabetic residents (#5, #8 and #9) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. The findings are: Review of the Center for Disease Control and Prevention (CDC) guidelines for infection control	D932		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA CREEK ASSISTED LIVING	2560 WILLARD ROAD WINSTON SALEM, NC 27107

(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
D932	Continued From page 13 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 resident, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Review of the facility's clinical standard operating procedure revealed: -It is the standard of the facility to maintain glucometers at optimal function based on manufacturer's guidelines and to adhere to strict infection control practices based on CDC guidelines. -Glucometers are sanitized weekly as per manufacturer's guidelines and calibrated weekly with results of calibration Observation of the facility's medication cart in the Memory Care Unit (MCU) on 06/30/21 at 11:24am revealed: -There were 3 plastic compartment containers with red lids in the second drawer of the medication cart. -Two of the containers had black pouches inside with alcohol pads. -Inside the black pouches were Brand A glucometers. -One of the container's had alcohol pads, but did not have a glucometer. -There was a glucometer loose in the medication cart that was not in a pouch or a container. -The MA picked up the glucometer and turned it over to the backside. -Resident #9's name was printed in black ink on the backside of the glucometer. Review of the Brand A glucometer instruction	D932		

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D932	Continued From page 14 manual revealed the Brand A glucometer was for single use only and should not be shared. 1. Review of Resident #5's current FL2 dated 10/21/20 revealed diagnoses included type II diabetes. Review of Resident #5's physician's orders dated 02/10/21 revealed there was an order for fingerstick blood sugars (FSBS) three times daily before meals. Review of Resident #5's Brand A glucometer history on 06/30/21 at 11:20am revealed: -The glucometer was set to the current date and time of 06/30/21 at 11:20am. -There were no FSBS readings in the glucometer history. Review of Resident #5's June 2021 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS three times daily scheduled for 7:30am, 11:30am and 5:00pm. -There were two FSBS results documented on 06/30/21 as follows: -There was a FSBS of 186 documented on 06/30/21 at 7:30am. -There was a FSBS of 142 documented on 06/30/21 at 11:30am. Review of another resident's Brand A glucometer history on 06/30/21 revealed FSBS readings which matched FSBS results that were documented on the eMAR for Resident #5 as follows: -There was a FSBS reading of 186 obtained at 7:06am. -There was a FSBS reading of 142 obtained at 10:51am.	D932		

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D932	Continued From page 15 Observation of Resident #5's medications on hand on 06/30/21 at 11:20am revealed: -The medication aide (MA) did not know where the resident's glucometer was located. -She asked the Memory Care Unit Coordinator (MCUC) where Resident #5's glucometer was located. -The MCUC came to the medication cart and pulled open the third drawer on the right side of the medication cart and handed the MA a hard-plastic compartment container with a red lid. -Inside one of the compartments of the plastic container was a Brand A glucometer. -There was piece of beige tape on the backside of the glucometer. -Resident #5's name was written with black ink on the tape. -When Resident #5's glucometer was turned on there were no FSBS readings in the glucometer history. Interview with the MA on 06/30/21 at 11:21am revealed: -She checked Resident #5's FSBS today at 11:00am. -When she checked the resident's FSBS she did not use the Resident #5's glucometer. -She used another resident's glucometer to check Resident #5's FSBS twice today because Resident #5's glucometer did not work. Based on observations, record reviews and interviews, it was determined Resident #5 was not interviewable. Refer to interview with the Memory Care Unit Coordinator (MCUC) on 06/30/21 at 11:26am. Refer to interview with the Administrator on	D932		

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D932	Continued From page 16 06/30/21 at 11:40am. 2. Review of Resident #8's current FL2 dated 03/24/21 revealed: -Diagnoses included type II diabetes mellitus, dementia, schizoaffective disorder, bipolar, transient cerebral ischemic attack. -There was an order to check finger stick blood sugar (FSBS) three times daily before meals. Review of Resident #8's Brand A glucometer history on 06/30/21 at 11:54am revealed: -The date and time on the glucometer were current as 06/30/21 at 11:54am. -There were no FSBS readings recorded in the glucometer history. Review of Resident #8's electronic Medication Administration Record (eMAR) revealed: -There was an entry for FSBS scheduled for 7:00am, 11:00am and 4:30pm. -There was a FSBS of 108 documented on 06/30/21 at 7:00am. -There was a FSBS of 102 documented on 06/30/21 at 11:00am. Review of another resident's Brand A glucometer history on 06/30/21 revealed FSBS readings which matched FSBS results that were documented on the eMAR for Resident #8 as follows: -There was a FSBS reading of 108 obtained at 6:45am. -There was a FSBS reading of 102 obtained at 10:48am. Based on observations, record reviews and interviews, it was determined Resident #8 was not interviewable.	D932		

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D932	Continued From page 17 Interview with the medication aide (MA) on 06/30/21 at 11:21am revealed: -She checked Resident #8's FSBS two times today. -When she checked the resident's FSBS she did not use the Resident #8's glucometer. -She used another resident's glucometer to check Resident #8's FSBS today. -After using the other resident's glucometer, she wiped the glucometer with an alcohol wipe. Refer to interview with the Memory Care Unit Coordinator (MCUC) on 06/30/21 at 11:26am. Refer to interview with the Administrator on 06/30/21 at 11:40am. 3. Review of Resident #9's current FL2 dated 09/14/20 revealed diagnoses included type II diabetes mellitus. Review of Resident #9's physician's order dated 01/18/21 revealed an order for fingerstick blood sugar (FSBS) once daily. Review of Resident #9's Brand A glucometer history on 06/30/21 at 11:58am revealed: -The glucometer was set to the current date 06/30/21 and time 11:58am. -There were 5 FSBS readings recorded in the glucometer history for 06/30/21 between 6:18am and 10:51am as follows: -There was a FSBS reading of 155 obtained at 6:18am. -There was a FSBS reading of 108 obtained at 6:45am. -There was a FSBS reading of 186 obtained at 7:06am. -There was a FSBS reading of 102 obtained at 10:48am.	D932		

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D932	Continued From page 18 -There was a FSBS reading of 142 obtained at 10:51am. Review of Resident #9's June 2021 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS once daily scheduled for 7:00am. -Resident #9 had one FSBS result of 155 documented at 7:00am on 06/30/21. Interview with the medication aide (MA) on 06/30/21 at 11:21am revealed: -She used Resident #9's glucometer to check two other resident's FSBS. -After each time Resident #9's glucometer was used, she wipe the glucometer with an alcohol pad. -She did not think there was a problem using the same glucometer for three residents. Based on observations, record reviews and interviews, it was determined Resident #9 was not interviewable. Refer to interview with the Memory Care Unit Coordinator (MCUC) on 06/30/21 at 11:26am. Refer to interview with the Administrator on 06/30/21 at 11:40am. Interview with the MCUC on 06/30/21 at 11:26am revealed: -The MAs cleaned the glucometers weekly using alcohol wipes. -The facilty policy was, the glucometer histories were cleared every Monday evening. -Each resident had their own glucometer for individual use. -There was no system in place to audit	D932		

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D932	Continued From page 19 glucometers and eMARs to ensure glucometers were not shared between residents because each resident had their own glucometer and they should not be shared. Interview with the Administrator on 06/30/21 at 11:40am revealed: -Sharing of glucometers between residents was a violation of policy and was strictly prohibited. -Each individual resident had their own glucometer that was labeled with the resident's name. -The glucometer should be stored inside a plastic container labeled with the resident's name. -If a resident's glucometer did not work the MA could obtain another glucometer from the office or notify the MCUC regarding the glucometer not working. -There should be no circumstances when staff shared a glucometer between residents. The facility failed to implement infection control procedures consistent with the Centers for Disease Control and Prevention (CDC) guidelines which resulted in staff sharing one glucometer between 3 diabetic residents, placing residents at risk for contracting bloodborne pathogen diseases. 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 in accordance with G.S. 131D-34 on 06/30/21. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 14, 2021.	D932		