

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2022
NAME OF PROVIDER OR SUPPLIER CAROLINA INN AT VILLAGE GREEN		STREET ADDRESS, CITY, STATE, ZIP CODE 400 FORSYTHE STREET FAYETTEVILLE, NC 28303			
(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 March 16, 2022, March 17, 2022 and March 18, 2022.	D 000			
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 1 of 3 sampled staff (Staff B) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: Review of Staff B's personnel record revealed: -The date of hire was documented as 09/26/19. -Her title at the facility was licensed practical nurse (LPN). -There was no documentation a HCPR check was completed for Staff B upon hire. Review of a HCPR check dated 03/18/22 revealed Staff B was not listed on the HCPR. Interview with the Administrator on 03/18/22 at 1:07pm revealed: -The corporate human resource (HR) department was responsible for performing the HCPR checks on newly hired employees.	D 137	Facility has implemented the use of an employee file checklist to ensure that no substantial findings were found on the HCPR prior to hire. Administrator will audit current employee records to ensure current employees have a HCPR check during an audit performed 4/1/2022. Administrator will sign off on employee file checklist to ensure HCPR checks are done prior to hire of new employees. Audit tool implemented 3/21/2022.	4/1/2022	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Janica Stefano, Administrator 04/21/2022
6899 9DYG11

Reviewed & Acknowledged *md, pw* 05/02/22

If continuation sheet 1 of 35

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D 137	Continued From page 1 -HCPR checks were completed upon hire. -The HR staff was responsible for ensuring pre-employment verification documentation was in the employee files at the facility. -The HR staff had already left for today (03/18/22). Interview with the Administrator on 03/18/22 at 2:30pm revealed: -She performed the HCPR check for Staff B today (03/18/22). -She thought the check done on Staff B's license that indicated no charges or disciplinary action had occurred could be used. -She would check to see if a previous HCPR check had been performed for Staff B. No additional information was provided for review.	D 137			
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure 1 of 3 sampled staff (Staff A) had a criminal background check completed upon hire. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 01/24/13 as a food service aide.	D 139	Facility has implemented the use of an employee file checklist to ensure that criminal background checks are done on employees prior to hire. Administrator will audit current employee records to ensure current employees have a criminal background during an audit performed 4/1/2022. Administrator will sign off on employee file checklist to ensure that criminal background checks are done prior to hire of new employees. Audited tool implemented 3/21/2022.		4/1/2022

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D 139	Continued From page 2 -Staff A transferred into a nursing assistant position on 03/23/15. -There was no consent for a criminal background check. -The was no documentation of a criminal background check performed. Interview with the Administrator on 03/18/22 at 2:16pm revealed: -There was no pre-employment criminal background check performed for Staff A. -Staff A gave her a copy of a criminal background check dated 12/17/21 she (Staff A) initiated in preparation to attend nursing school. Second interview with the Administrator on 03/18/22 at 2:27pm revealed: -Human Resources (HR) staff was responsible for performing pre-employment verification for criminal background checks. -She did not have a system in place to audit personnel records. -A checklist was completed upon hire but if the employee was hired prior to the facility initiation of the checklist, then a new hire checklist had not been completed. -The HR staff had already left for today (03/18/22).	D 139			
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.	D 282			

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D 282	Continued From page 3 This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure the kitchen was clean and protected from contamination related to food particles and build-up substances on a gas top grill and a build-up substance on the overhead hood vent in the kitchen. The findings are: Observation of the kitchen on 03/16/22 at 2:37pm revealed: -There was build-up of a brownish, yellow colored substance on the metal vents of the overhead hood vent located over the flat top grill and deep fryer. -There was a large metal pan stored on top of the gas top grill. The grill crates were not visible with the large metal pan stored on the grill. -There was a hand-held large strainer/spatula stored underneath the gas top grill. -The grill stand with a bottom shelf was heavily soiled and discolored with a variety of orange, brown and white colored substances. -There was a greasy build-up substance on the surface of the gas top grill's burner control knobs. -The grill stand was greasy to touch. Observation of the kitchen on 03/17/18 at 11:25am revealed: -The gas top grill grates had a heavy build-up of black food particles stuck on the surface, edges and sides of the grates. -There were scattered tan and black colored chunks of food particles adhered on and in between the grill grates and edges of the back section of the grills cooking surface. -There was a thick build-up of greasy, black food	D 282	1. The Dining Consultant and Dietary Manager will revise the cleaning checklist that includes the cadence of weekly deep cleaning of all kitchen equipment The compliance to the procedure will be monitored weekly x 12 weeks by the Dining Manager. If the checklist is completed properly the procedure will then be monitored each month x 12 months. If there is documentation of soiled equipment the checklist will be monitored weekly x 12 weeks until it is clean 95% of the time. A report will be turned in to the administrator monthly and the Quality Assurance Committee as scheduled by the Dining Consultant. 2. The dining consultant and DM will revise the Dishwasher's on-boarding training guide to ensure cleaning checklists are a part of the on-boarding experience. The compliance to the procedure will be monitored during the 90-day on-boarding period weekly x12 weeks by the Dining Manger. If the checklist is completed properly the procedure will then be monitored each month x 12 months. If there is documentation of soiled equipment the checklist will be monitored weekly x 12 weeks until it is clean 95% of the time. A report will be turned in to the Administrator monthly and the Quality Assurance Committee as scheduled by the Dining Consultant.	4/20/2022

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D 282	Continued From page 4 particles along the inner side brackets and front bracket located above the gas grill's drip pan. -There was a greasy build-up substance on the surface of the gas grill's burner control knobs. -The grill stand with a bottom shelf was heavily soiled and discolored with a variety of orange, brown and white colored substances. -The grill stand was greasy to touch. -There was build-up of a brownish yellow colored substance on the metal vents of the overhead vent hood located over the flat top grill and deep fryer. Review of the facility's Food Establishment Inspection Report dated 11/27/17 revealed. -The score was 90. -Observations and corrective action comments included equipment food contact surfaces should be clean to sight and touch. Interview with a cook/dishwasher on 03/18/22 at 8:47am revealed: -His role was mainly dishwashing however, he worked as a cook occasionally. -Cleaning of the kitchen was completed by all dietary staff. -The gas top grill was deep cleaned every Saturday. -The kitchen staff had a cleaning schedule, but he had not seen a written schedule for cleaning. -He had not used the gas grill this week. -All cooking appliances should have been cleaned and sanitized after meals were prepared. -The burned food being on the contact surfaces on the grill could have caused contamination of the food being prepared for the residents. Observation in the kitchen on 03/18/22 at 4:44pm revealed: -Dietary staff were cleaning the gas top grill and	D 282			

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D 282	Continued From page 5 grates. -The overhead hood's metal vents had been cleaned with no brownish, yellow colored substances remaining. Review of a daily written cleaning schedule checklist form revealed: -There was a space for the dietary staff to sign and date the form when tasks were completed. -Tasks included to clean and sanitize all appliances. Telephone interview with the county Inspector with environmental health on 03/18/22 at 11:45am revealed it was very important to ensure foods were protected from contamination from surfaces and appliances in which food came into contact with as well as surfaces that did not have contact with food in order to prevent any chances of contamination of the foods being served to the residents. Interview with the Dietary Manager (DM) on 03/18/22 at 4:40pm revealed: -She had assigned an Executive Chef to ensure the cleaning needs of the kitchen and appliances were completed each shift by the dietary staff. -The Executive Chef resigned a few weeks ago and because there were several new dietary staff, she was staying in the dining areas and kitchenettes more to monitor the new staff when residents' meals were plated and served to the residents. -She expected the kitchen staff to ensure all areas of the kitchen were cleaned each shift to ensure all surface areas in the kitchen were cleaned thoroughly to avoid contaminating the residents' food being prepared. Interview with the Administrator on 08/25/21 at	D 282			

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D 282	Continued From page 6 11:11am revealed: -The DM was responsible for the overall operation in the kitchen including cleaning. -She monitored the kitchen areas during the week. -She expected the kitchen and surface areas to be cleaned and sanitized to ensure foods were protected from contamination.	D 282			
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure snacks were offered to all residents between meals. The findings are: Interview with two residents on 03/16/22 at 9:32am revealed: -Facility staff offered snacks to residents one time a the day in the afternoon. -Facility staff did not pass snacks to their room three times per day (between meals). -The two residents kept their own personal snacks in their room. Interview with the Dietary Manager (DM) on	D 298	1. The Dining consultant and DM will revise the snack checklist that includes the cadence of passing daily snacks to all residents three times daily at 10am, 2pm & 8pm. The compliance to the procedure will be monitored weekly x 12 weeks by the Dining Manager. If the checklist is completed properly the procedure will then be monitored each month x 12 months. If there is documentation of missed snacks, the checklist will be monitored weekly x 12 weeks until there is compliance 95% of the time. A report will be turned in to the Administrator monthly and the Quality Assurance Committee as scheduled by the Dining Consultant.	4/20/2022	

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D 298	Continued From page 7 03/17/22 at 9:15am revealed: -At 3:00pm, a dietary server walked through each floor and offered water, drinks and snacks. -Dietary staff prepared bedtime snacks for staff to use for the residents that were diagnosed with diabetes in case a residents' blood sugar level dropped at night. -The bedtime snacks prepared for residents with diabetes were kept on each floor in case facility staff needed a snack for the residents. -A snack was offered to each resident one time per day however, the facility had an "all day menu" that included snacks, soups, salads, and sandwiches for residents. Observation of a resident on 03/18/22 at 11:29am revealed: -The resident approached the medication aide (MA). -The resident requested something to eat and asked the MA when they went to eat. -The MA told the resident it would be time to eat shortly. Interview with the MA on 03/18/22 at 11:30am revealed: -She had not seen any snacks offered to the residents when she worked. -Snacks were only passed in the evening. -The dietary staff were responsible for passing out snacks to the residents. Second observation of the resident on 03/18/22 at 11:35am revealed: -The resident approached the MA a second time and stated she was hungry. -The MA told the resident she would get her something to eat. -The MA returned at 11:40am with a sandwich and gave the sandwich to the resident.	D 298			

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D 298	Continued From page 8 -The MA told the resident lunch would be served at 12:00pm. Interview with two residents on 03/18/22 between 11:35am and 11:40am revealed: -The residents stated they were hungry. -The residents were not served snacks. Interview with a third resident on 03/18/22 at 11:42am revealed: -She did not get served snacks. -"Every once in a while", someone would come by her room with a basket full of candy bars and other food items, but did not come every day. -No one had been to her room in the last week with the basket of snacks. Interview with the DM on 03/18/22 at 12:14pm revealed she was not aware that snacks should have been offered or made available to all residents between each meal three times per day. Interview with the Administrator on 03/18/22 at 5:28pm revealed she expected snacks to be offered to each resident three times daily.	D 298			
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310			

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D 310	Continued From page 9 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to serve therapeutic diets as ordered for 2 of 2 sampled residents who had diet orders for nectar thickened liquids (#1 and #6). The findings are: Observation of the labeled instructions on the container of the thickening agent in the kitchen on 03/18/22 at 4:43pm revealed: -There was a container of a powdered thickening agent. (A thickening agent is a powder that is dissolved in liquids to thicken thin liquids to a desired consistency when thin liquids were difficult to swallow, to prevent choking and prevent liquids from entering the lungs during the swallowing process). -There was a dual ended blue measuring device inside of the container. One end was labeled as one tablespoon and the other end labeled one teaspoon. -There were labeled directions including "tsp" = teaspoon, "T" = tablespoon with instructions 3 teaspoons were in one tablespoon. -The manufacturer's label had directions for nectar thick consistency to add 2 T and 2 tsp to 8 fluid ounces of liquid. -There were instructions to stir the liquid with the added thickening agent for 15 seconds until dissolved, allow 1-4 minutes for the product to reach the desired thickness. Observation of the dietary server on 03/17/22 at 11:40am revealed: -The dietary server poured tea into two beverage containers with no ice.	D 310	The Dining Consultant and DM will revise the procedure for thickened liquids given to residents that includes: 1. The purchasing of measuring implements 2. The purchasing of pre-thickened liquids in Nectar consistency The compliance to the procedure will be monitored weekly x 12 weeks by the Dining Manager using the IDDSI flow test. If completed properly the procedure will then be monitored each month x 12 months. If there is documentation of inaccurate liquid flow, the checklist will be monitored weekly x 12 weeks until there is compliance 95% of the time. A report will be turned in to the Administrator monthly and the Quality Assurance Committee as scheduled by the Dining Consultant. 2. The Dining Consultant and DM will revise the servers on-boarding training guide to ensure thickened liquids are a part of the on-boarding experience. The compliance to the procedure will be monitored during the 90-day on-boarding period weekly x12 weeks by the Dining Manager. If the checklist is completed properly the procedure will then be monitored each month x 12 months. If there is documentation of inaccurate thickened liquids the checklist will be monitored weekly x 12 weeks. A report will be turned in to the Administrator monthly and the QA committee as scheduled by Dining Consultant.	4/20/2022	

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D 310	Continued From page 10 -The tea poured in the beverage containers were approximately 1 inch or more away the rim of the container. -The dietary server did not measure the amount of tea poured into each beverage container. -The dietary server added 2 T and 2 tsp of the thickening agent into each of the two-beverage containers using the measuring device inside the thickening agent container. -The dietary server reviewed the labeled manufactured instructions for nectar thick liquids. -The dietary server stirred the thickening agent that was added to the tea in the two beverage containers until dissolved and stated the tea was at nectar consistency and was ready to be served to the residents. -The spoon used to stir the thickening agent in each container of tea held in a straight up position in the tea mixed with the thickening agent after the dietary server stopped stirring. -Each beverage container with the tea and the thickening agent was placed on individual serving trays. Observation of Resident #1 during the lunch meal on 03/17/22 between 12:03pm - 12:43pm revealed: -Resident #1 was served his meal in his room. -The resident was sitting in an upright position in his wheelchair. -At 12:05pm, the resident was served his lunch meal on a serving tray with the tea prepared thicker than nectar thick and one 8-ounce bottle of water that was not thickened to a nectar thick consistency. -The resident was alone in the room and feeding himself. -At 12:10pm, the resident was eating his meal and picked up the opened bottle of water and drank some of the water, then resumed eating his	D 310			

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D 310	Continued From page 11 meal again. -There was no coughing noted by the resident. -At 12:11pm, a dietary server was prompted regarding the water not being served to the resident in a nectar thick consistency. -At 12:16pm, the dietary server removed the water from the resident's tray. -The resident was not observed attempting to drink the tea that was served thicker than a nectar consistency. -After being prompted, the Nurse in Charge (NIC) asked the resident if he was having a hard time drinking the tea and the resident shook his head yes. -The NIC told the resident he would prepare the resident another beverage. -At 12:46pm the resident was served a beverage in a nectar thick consistency. Interview with the NIC on 03/17/22 at 12:29pm revealed: -Resident #1's tea was served to the resident in a pudding like consistency instead of nectar consistency. -He prepared Resident #1's nectar thick liquids again and served it to the resident. Observation of Resident #1 during the lunch meal on 03/17/22 at 12:46pm revealed the resident was served a beverage in a nectar thick consistency. Observation of Resident #6 during the lunch meal on 03/17/22 between 12:10pm - 12:16pm revealed: -Resident #6 was served his meal in his room. -The resident was sitting in an upright position in his wheelchair. -The resident was served his lunch meal on a serving tray with tea prepared thicker than nectar	D 310			

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D 310	Continued From page 12 thick and one 8-ounce bottle of water that was not thickened to a nectar thick consistency. -There was a staff in the room assisting the resident with his meal. -At 12:11pm a dietary server was prompted regarding the water not being served to the resident in a nectar thick consistency. -At 12:16pm the dietary server removed the water from the resident's tray and stated that the water should have been served to the resident in a nectar thick consistency. -There was no coughing noted by the resident. Observation of the Dietary Manager (DM) on 03/18/22 at 4:48pm revealed: -The DM used a measuring cup to measure 8 fluid ounces of water. -The DM poured the 8 ounces of water into the same beverage container used to thicken the residents' liquids by the server on 03/18/22 at 4:43pm. -The liquids were approximately ½ inch from the rim of the container. Interview with the Assistant DM on 03/17/22 at 2:30pm revealed all dietary staff were responsible for and trained to prepare the powdered thickening agent for the residents with orders for thickened liquids during meals. 1. Review of Resident #1's current FL-2 dated 10/15/21 revealed: -Diagnoses included status post cerebral vascular accident, congestive heart failure, atrial fibrillation, depression, arteriosclerotic heart disease and hypertension. -There was an order for a mechanical soft diet with thin liquids. -The resident was intermittently disoriented.	D 310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2022
NAME OF PROVIDER OR SUPPLIER CAROLINA INN AT VILLAGE GREEN		STREET ADDRESS, CITY, STATE, ZIP CODE 400 FORSYTHE STREET FAYETTEVILLE, NC 28303			
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D 310	Continued From page 13 Review of Resident #1's current assessment and care plan dated 10/15/21 revealed the resident required supervision, set up assistance and cues from staff when eating. Review of a subsequent diet order for Resident #1 dated 01/26/22 revealed an order for nectar thick liquids at meals and may have thin water in between meals, no straws. Review of Resident #1's Speech Therapist (ST) visit note dated 02/03/22 revealed: -The resident was diagnosed with dysphagia following a cerebral infarction. -The resident's short-term goals included to safely swallow nectar thick liquids and mechanical soft foods, and soft vegetables. -The resident continued to exhibit coughing and choking episodes with thin liquids while eating at mealtime. -The resident could swallow nectar thickened liquids with his meals. -The resident was safely swallowing thin liquids and water if he was not eating with it. -The resident may have thin water in between meals. -During meals he should drink nectar thick liquids. -The resident's goals were met at that time and the resident was discharged from ST services. Review of the facility's undated diet list revealed Resident #1 was to be served nectar thick liquids. Interview with Resident #1's private sitter on 03/17/22 at 8:20am revealed: -She worked at the facility as a medication aide (MA) and performed private duty aide services for the resident when she completed her shift at the facility.	D 310			

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D 310	Continued From page 14 -When Resident #1 was eating he drank his liquids too fast and "sucks" liquids down his windpipe. -The facility served Resident #1 nectar thickened liquids with his meals. Based on observation, interviews and record reviews, Resident #1 was not interviewable. Attempted telephone interview with Resident #1's PCP on 03/18/22 at 2:45pm was unsuccessful. Refer to the interview with the dietary server observed preparing the powdered thickening agent for the residents thickened liquids during the 03/17/22 lunch meal on 03/17/22 at 1:03pm. Refer to the interview with the Dietary Manager (DM) on 03/18/22 at 4:44pm. Refer to the interview with the Administrator on 03/18/22 at 5:28pm. 2. Review of Resident #6's current FL-2 dated 11/01/21 revealed: -Diagnoses included Alzheimer disease, bipolar affective disorder and anxiety. -There was an order for a low sodium diet. Review of Resident #6's current assessment and care plan dated 12/15/21 revealed: -The resident was always disoriented with significant memory loss requiring direction. -The resident required supervision, set up assistance and cues from staff when eating. Review of primary care provider (PCP) orders for Resident #6 revealed: -There was an order dated 03/08/22 for speech therapy services to evaluate and treat due to	D 310			

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D 310	Continued From page 15 coughing with liquids. -There was an order dated 03/15/22 for speech therapy services to treat oropharyngeal dysphagia for diet texture analysis and compensatory strategies three times weekly for 9 weeks. -There was a diet order dated 03/15/22 for nectar thick liquids with mechanical soft, chopped meats, discontinue thin liquids. Interview with a dietary server on 03/17/22 at 11:40am revealed Resident #6 had a new order for nectar thickened liquids. Telephone interview with a Speech Therapist (ST) on 03/18/22 at 1:07pm revealed: -She evaluated Resident #6 on 03/15/22 and recommended nectar thickened liquids for Resident #6 because he was showing signs and symptoms of aspiration with thin liquids by coughing. -When a resident coughed after drinking thin liquids it could indicate the thin liquids were falling back into the airway. -On 03/15/22, she recommended for Resident #6 to have a modified barium swallow study scheduled. (A modified barium swallow study is a diagnostic test using x-rays as a person eats or drinks a variety of consistencies to visualize structures of the throat as the swallowing process occurs to determine if foods or liquids were going into the esophagus instead of the trachea (airway). -Resident #6 should have been served nectar thickened liquids as ordered during the lunch meal on 03/17/22 until the resident had a barium swallow study performed to determine the reasons the resident was coughing when drinking thin liquids in order to keep the resident as safe as possible.	D 310			

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D 310	Continued From page 16 Based on observation, interviews and record reviews, Resident #6 was not interviewable. Attempted telephone interview with Resident #6's PCP on 03/18/22 at 2:45pm was unsuccessful. Refer to the interview with the dietary server observed preparing the powdered thickening agent for the residents thickened liquids during the 03/17/22 lunch meal on 03/17/22 at 1:03pm. Refer to the interview with the Dietary Manager (DM) on 03/18/22 at 4:44pm. Refer to the interview with the Administrator on 03/18/22 at 5:28pm. Interview with the dietary server observed preparing the powdered thickening agent for the residents thickened liquids during the 03/17/22 lunch meal on 03/17/22 at 1:03pm revealed: -She had worked at the facility since October 2021. -She was trained by another dietary staff at the facility how to mix the residents' thickened liquids. -Thickened liquids were ordered when a resident had trouble swallowing liquids. -She knew the residents' beverage containers were 8-ounces because that was one of the sizes the facility always purchased for the residents. -She thought nectar thickened liquids should look like applesauce. -Nectar thickened liquids were mixed correctly when the spoon would "stick straight up" in the liquids with the added thickener. -She had placed the 8-ounce bottles of water on Resident #1's and Resident #6's serving tray when prepping for the lunch meal, "it was an oversight" and she should have thickened the residents' water.	D 310			

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D 310	Continued From page 17 Interview with the Dietary Manager (DM) on 03/18/22 at 4:44pm revealed: -The dietary server should have measured the liquids being poured into the resident's beverage container prior to preparing the nectar thickened liquids to ensure the thickener was mixed to the ordered consistency. -She trained dietary staff to always measure the liquids being thickened with an incremented measuring cup. -During each shift when meals were provided either her, the Supervisor over the kitchen or Assistant Manager were present during meals to oversee dietary staff and ensure residents meals were served as ordered. -A Speech Therapist came to the facility today, 03/18/22 and reviewed how to mix thickened liquids for Resident #1 and Resident #6. Interview with the Administrator on 03/18/22 at 5:28pm revealed: -She observed meals being served to residents. -She expected for residents' meals to be served as ordered.	D 310			
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358	All LPN's and Med Aides inserviced on proper protocol for MD orders including transcribing and noting MD orders onto MARS including discontinuing orders. New 11-7 nightly audits implemented (See 11-7 nightly audit checklist-attached) to be submitted to Nurse in Charge every A.M.	4/20/2022	

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D 358	Continued From page 18 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 5 sampled residents (#3) including administration of an antibiotic and leaving medications at bedside. The findings are: - Review of Resident #3's current FL-2 dated 06/11/21 revealed diagnoses included pulmonary emphysema, hypertension (HTN), hyperlipidemia, hypothyroidism and macular degeneration. - Observation in Resident #3's room on 03/17/22 at 8:27am revealed: - The resident was sitting in her wheelchair in front of a bedside table eating a banana for breakfast. - There was a clear medication cup containing a blue capsule. - There was a boxed labeled Clotrimazole and Betamethasone 1%/0.05% with a faded prescription label that was unreadable. (Clotrimazole and Betamethasone is a topical cream used to treat fungus infections). Interview with Resident #3 on 03/17/22 at 8:25am revealed: - The blue capsule was her medication and she took the medication when she completed her breakfast meal. - She was going to take the medication after she completed her breakfast meal. - She kept the topical cream in her room and occasionally used it when needed. A second interview with Resident #3 on 03/17/22 at 12:36pm revealed she took her medication (capsule) after she completed her breakfast this	D 358	New admission audits to be reviewed x2 nurses within 24 hrs using admission checklist-attached and submitted to Nurse in Charge within 24 hrs. per the following schedule: For each floor any admissions on 7-3 shift will be reviewed by 3-11 shift using the admission checklist. (exception-1st floor 7-3 admission will be reviewed by 11-7 LPN) Any admissions arriving 3-11 shift will be reviewed by 7-3 shift using Nursing Admission Checklist. Must be turned into Nurse in Charge within 24hrs. 11-7 LPN or Med Aide will also review all new admissions using the Admission Checklist the night of resident admission. Must be turned into Nurse in Charge by the following A.M. New chart audit checklist implemented to be completed by LPN's and Med Aides monthly as assigned. Nurse in Charge and RN Supervisor will review chart audits in Standards of Care meeting weekly		

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D 358	Continued From page 19 morning, 03/17/22 . Interview with the licensed practical nurse (LPN) on 03/17/22 at 8:33am revealed: -Resident #3 had an order to self-administer medications. -Resident #3 could keep medications in her room. -"A lot" of the residents residing at the facility had orders to self-administer medications. -Resident #3 did not like for staff to stand over her when she took her medications. A second interview with the LPN on 03/17/22 at 1:45pm revealed: -Resident #3 did not have an order to self-administer her medications. -She prepared and administered Resident #3's medications this morning, (03/17/22), however the resident left one capsule in the medication cup. -Resident #3 was waiting so long to take the capsule, so she left the medication in the cup for the resident to take. -Resident #3 normally took all her medications without any delays when her medications were administered. -She should have observed Resident #3 swallow the medication instead of leaving the medication in the room for the resident to take. -Resident #3 should not have any medications stored in her room. -She returned to Resident #3's room and disposed of the topical medication (Clotrimazole and Betamethasone 1%/0.05%). Interview with the RN Supervisor on 03/18/22 at 2:55pm revealed it was the responsibility of the nurse and medication aide (MA) to observe residents take all medications.	D 358			

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D 358	Continued From page 20 Attempted telephone interview with Resident #3's primary care provider (PCP) on 03/18/22 at 3:17pm was unsuccessful. b. Review of Resident #3's hospital After Visit Summary dated 02/21/22 revealed there was an order for Ciprofloxacin (Cipro) 500mg twice a day for 5 days. (Cipro is an antibiotic used to treat infections.) Review of Resident #3's February 2022 medication administration record (MAR) revealed: -There was an entry for Ciprofloxacin 500mg twice a day for 5 days with scheduled administration times at 8:00am and 8:00pm. -Ciprofloxacin was documented as administered from 02/26/22 - 02/28/22. Review of Resident #3's March 2022 MAR revealed there was no entry for Ciprofloxacin. Interview with the registered nurse (RN) Supervisor on 03/18/22 at 1:00pm revealed: -Resident #3 signed out of the hospital against medical advice (AMA) on 02/21/22 and the hospital After Visit Summary was not available when she readmitted to the facility. -Resident #3's family member picked up the Cipro from the hospital's pharmacy and brought it back to the facility on 02/25/22. -The Cipro was added to Resident #3's February 2022 MAR and was administered 02/26/22 - 02/28/22. -She was not sure why the Cipro was not on Resident #3's March 2022 MAR for the remaining doses. Interview with a facility licensed practical nurse (LPN) on 03/18/22 at 2:40pm revealed: -Resident #3 was sent to the hospital for rectal	D 358		

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D 358	Continued From page 21 bleeding on 02/21/22. -Resident #3 left the hospital AMA and did not have the hospital After Visit Summary when she readmitted to the facility. -Resident #3's family member picked up the Cipro prescription from the hospital's pharmacy and brought the medication and the hospital After Visit Summary back to the facility. -The Cipro order was added to Resident #3's February 2022 MAR and the first dose was administered on 02/26/22. -The Cipro order was not transcribed onto Resident #3's March 2022 MAR. -It was the responsibility of the nurses and the medication aides (MA) to compare the medication labels with the MAR 3 times for accuracy prior to administration. A second interview with the RN Supervisor on 03/18/22 at 2:55pm revealed it was the responsibility of the nurse and the MA to compare the medication label with the MAR for accuracy prior to administering medications. Interview with the nurse in charge (NIC) on 03/18/22 at 5:40pm revealed: -It was the responsibility of the nurse and the MA to hand write new orders received on the resident's current MAR and fax the orders to the pharmacy. -It was the responsibility of the pharmacy to update the following month's MAR with the new orders received. -It was the responsibility of the night shift nurse and MA to review all MARs at the end of the month and compare them with the new MARs for accuracy. Attempted telephone interview with Resident #3's family member on 03/18/22 at 3:16pm was	D 358			

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D 358	Continued From page 22 unsuccessful. Attempted telephone interview with Resident #3's primary care provider (PCP) on 03/18/22 at 3:17pm was unsuccessful.	D 358			
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: .Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to infection prevention requirements. The findings are: Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures for glucometers used to obtain finger stick blood sugar (FSBS) readings for 2 of 3 sampled residents (#7 and #8) with an order for FSBS monitoring. [Refer to Tag 932, G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (Type B Violation)].	D912	Residents of Carolina Inn at Village Green receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. Please see POC for D932	4/20/2022	
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection	D932	All LPNs and Med Aides inserviced on proper protocol and infection control measures for blood glucose monitoring (See attached)		

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D932	Continued From page 23 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.	D932	All glucometers will be labeled and in separate bags for each resident Each shift will assure glucometers are in separate bags and labeled at beginning of each shift during narcotic count as evidenced by signatures on narcotic sheets. 11-7 LPN or Med Aide will ensure each resident has glucometer that is labeled and separately bagged during nightly audit. (See attached form "11-7 Nightly Audit Checklist") Audit sheets will be turned into Nurse in Charge every A.M. Any concerns or needs will be addressed promptly. Germicidal wipes will be added to each med cart.	4/20/2022	

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STATE FORM

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NAME OF PROVIDER OR SUPPLIER CAROLINA INN AT VILLAGE GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 400 FORSYTHE STREET FAYETTEVILLE, NC 28303		
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D932	Continued From page 25 device, and two of three black zippered pouches, from the right top drawer of the medication cart. -The MA unzipped pouch #1. There was a clear piece of tape with unidentifiable faint markings fastened to the outer covering of pouch #1. -There was an unlabeled glucometer (Brand A) and a container of glucometer strips inside pouch #1. -The MA unzipped pouch #2, which was not labeled. There was an unlabeled glucometer (Brand A) and a pharmacy labeled vial of Humalog insulin for Resident #7 (used to lower blood sugar levels) inside pouch #2. Observations of the third black zippered pouch in the medication drawer on 03/17/22 between 11:05am and 11:10am revealed: -The pouch was unlabeled. -There was an unlabeled glucometer (Brand B) and a container of glucometer strips labeled for Resident #8 inside the pouch. Observations of the top of the medication cart on 03/17/22 between 11:05am and 11:25am revealed: -There was a bottle of foam hand sanitizer. -There were no disinfectant wipes on the medication cart. Review of the facility copy of the Center for Disease Control (CDC) guidelines for infection control revealed blood glucose meters should not be shared. Review of the Center for Disease Control (CDC) guidelines for infection control revealed the following recommendations for blood glucose monitoring devices: -Glucometers should not be shared between residents.	D932			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CAROLINA INN AT VILLAGE GREEN

400 FORSYTHE STREET

FAYETTEVILLE, NC 28303

(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 26 -If a 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 the manufacturer's user manual for Brand A glucometers revealed: -The glucometer is for single patient use only and not to be used on multiple patients. -Using the same Brand A type glucometer to collect blood on more than one person poses a risk of transmitting blood-borne pathogens such as Hepatitis B or HIV. -All parts of the blood glucose monitoring system can potentially transmit infectious diseases, even after cleaning and disinfection. Review of the manufacturer's user manual for Brand B glucometers revealed: -The blood glucose system is for one person use only. -The glucometer should not be shared or used on multiple patients. -All parts of the blood glucose monitoring system could carry blood-borne pathogens after use, even after cleaning and disinfecting. -If the blood glucose monitoring system is to be used on multiple patients, cleaning and disinfection of the meter should be done between patients. -Only a disinfectant product approved and registered with the environmental protection agency (EPA) should be used for cleaning and disinfecting the meter by rubbing the entire outside of the meter using 3 circular wiping motions with moderate pressure on the front, back, left side, right side, top and bottom of the meter. The meter should remain wet for 2	D932		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2022
NAME OF PROVIDER OR SUPPLIER CAROLINA INN AT VILLAGE GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 400 FORSYTHE STREET FAYETTEVILLE, NC 28303		
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D932	Continued From page 27 minutes. Never put meter in liquids or allow any liquids to enter the test port. 1. Review of Resident #7's current FL-2 dated 07/12/21 revealed: -Diagnoses included weakness and malaise. -There was no diagnosis for diabetes mellitus listed on the current FL-2. -There was a physician's order for accuchecks (fingerstick blood sugar checks) twice daily between meals. Interview with the MA on 03/17/22 at 11:05am revealed: -She was preparing to check a FSBS for Resident #7. -Resident #7 had two glucometers. -She knew both the glucometers were for Resident #7 because of the type of glucometers they were (Brand A), and pouch #2 contained the resident's pharmacy labeled insulin vial. -On "yesterday" (03/16/22), she used the unlabeled glucometer from pouch #1. -She used that glucometer because she was told by another staff (unnamed) that pouch #1 belonged to Resident #7. Second interview with the MA on 03/17/22 at 11:22am revealed: -She last participated in an infection control training during the summer of 2021. -She did not know why she used the unlabeled glucometer. -She should have contacted the Nurse-in-Charge before using the unlabeled glucometer. Interview with the Nurse-in-Charge on 03/17/22 at 11:19am revealed: -Each resident that got fingerstick blood sugar checks had their own glucometer.	D932			

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D932	Continued From page 28 -The MAs must be able to identify each resident's glucometer. -The MAs are supposed to use each resident's designated glucometer. -He could not identify the glucometers in the zippered pouches belonged to Resident #7 because the glucometers inside the zippered pouches were not labeled with Resident #7's name. -Inside one of the zippered pouches in a plastic bag was Resident #7's labeled insulin which would identify the items inside the pouch belonging to Resident #7. Review of Resident #7's March 2022 medication administration record (MAR) revealed: -There was a printed entry for FSBS checks twice a day with sliding scale insulin coverage scheduled at 11:00am and 4:00p. -FSBS values were documented on the MAR two times a day from 03/01/22 to 03/16/22 with results ranging from 102 - 232. Review of Resident #7's Blood Sugar Record (no month identified) revealed FSBS values were documented on the Blood Sugar Record two times a day at lunch and dinner from 03/01/22 to 03/16/22 with results ranging from 102 - 232. Review of the history of FSBS values in glucometer #1, identified for Resident #7, revealed: - The first result shown on the glucometer was 128 and dated 06/01. There was no year. -There were 23 blood sugar readings in the Brand A glucometer #1 for Resident #7. The first blood sugar reading shown on the glucometer, which was 128 (glucometer date 06/01), matched the blood sugar reading for 03/16/22 at 4:00pm documented on Resident #7's MAR and Blood	D932			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/18/2022
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D932	Continued From page 29 Sugar Record. -The 23rd blood sugar reading was 143 (glucometer date 05/17), matched the blood sugar reading for 03/01/22 at 11:00am documented on Resident #7's MAR and Blood Sugar Record. -FSBS values recorded in the history of the glucometer were not consistent with FSBS readings documented on the resident's 03/2022 MAR and Blood Sugar Record. -Examples of FSBS values recorded in the history of glucometer #1 that were not consistent with the FSBS results on the 03/2022 MAR included the following: -On the date of 05/27 (no year), there were three blood sugar readings. At 12:00pm there was a blood sugar reading of 91, which was not documented on Resident #7's 03/2022 MAR or Blood Sugar Record. At 6:28 pm, there was a blood sugar reading of 104, which was consistent with the FSBS reading documented on the 03/2022 MAR at 11:00am and the Blood Sugar Record for 03/11/2022. At 11:17pm, there was a blood sugar reading of 145, which was consistent with the FSBS reading documented on the 03/2022 MAR at 4:00pm and Blood Sugar Record for 03/11/2022. -On the date of 05/26 (no year) at 6:43pm, there was one blood sugar reading of 169, which was not documented on Resident #7's 03/2022 MAR or Blood Sugar Record. -On the date of 05/23 (no year), there were three blood sugar readings. At 2:05am there was a blood sugar reading of 193 (consistent with the blood sugar reading for 03/06/22 at 4:00pm). At 6:22 pm, there was a blood sugar reading of 120 (consistent with the blood sugar reading for 03/07/22 at 11:00am). At 11:43pm, there was a blood sugar reading of 130, which was not consistent with the next blood sugar reading of	D932			

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D932	Continued From page 30 132 documented on Resident #7's 03/2022 MAR or Blood Sugar Record. -There were multiple FSBS readings on the 03/2022 MAR and Blood Sugar Record that were not found in the history of the Brand A #1 glucometer for Resident #7 with examples as follows: -On 03/02/22 at 11:00am, there was a documented FSBS reading on the 03/2022 MAR and Blood Sugar Record for 126 that was not found consecutive in the glucometer history. -On 03/03/22 at 11:00am, there was a documented FSBS reading on the Blood Sugar Record for 115 that was not found in the glucometer history. The FSBS reading documented on the 03/2022 MAR for 03/03/22 at 11:00am was 128. The FSBS result of 128 was not found consecutive in the glucometer history. -On 03/05/22 at 4:00pm, there was a documented FSBS reading on the 03/2022 MAR and Blood Sugar Record for 110 that was not found consecutive in the glucometer history. -On 03/07/22 at 4:00pm, there was a documented FSBS reading on the 03/2022 MAR and Blood Sugar Record for 132 that was not found consecutive in the glucometer history. -On 03/08/22 at 4:00pm, there was a documented FSBS reading on the 03/2022 MAR and Blood Sugar Record for 147 that was not found consecutive in the glucometer history. -On 03/16/22 at 11:00am, there was a documented FSBS reading on the 03/2022 MAR and Blood Sugar Record for 109 that was not found consecutive in the glucometer history. Review of the history of FSBS values in glucometer #2, identified for Resident #7, revealed: - The first result shown on the glucometer was 112 and dated was 04/16.	D932			

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D932	Continued From page 31 -There were 19 blood sugar readings in the Brand A glucometer #2 for Resident #7. The last blood sugar reading, which was 112 (glucometer date 04/16) and did not match any of the blood sugar readings documented on Resident #7's MAR and Blood Sugar Record. The 19th blood sugar reading was 100 (glucometer date 04/02) and did not match any of the blood sugar reading documented on Resident #7's MAR and Blood Sugar Record. -Of the 19 blood sugar readings in the Brand A glucometer #2 for Resident #7, there were two blood sugar readings that matched FSBS readings on the 03/2022 MAR and Blood Sugar Record for Resident #7. -It could not be determined the actual date the FSBS readings were collected. Interview with an LPN on 03/18/22 at 2:54pm revealed: -She was able to tell which glucometer belonged to Resident #7. -Resident #7's glucometer was not labeled. -Resident #7 was hard of hearing and his glucometer announced the blood sugar result. -Resident #7's glucometer was "the biggest". Refer to interview with the Nurse-in-Charge on 03/17/22 at 2:00pm. Refer to interview with the Administrator on 03/18/22 at 3:01pm. Refer to interview with the RN Supervisor on 03/18/22 at 3:03pm. 2. Review of Resident #8's March 2022 medication administration record revealed: -There was a printed entry for blood sugar checks (FSBS) twice a day scheduled at 6:00am and	D932			

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D932	Continued From page 32 8:00pm. -There was documentation of FSBS results ranging from 88 - 161 from 03/01/22 at 6:00am through 03/17/22 at 8:00pm. -There was documentation of a dinner time FSBS reading of 96 for 03/15/22. Review of Resident #8's Blood Sugar Record revealed FSBS readings were documented on the Blood Sugar Record two times a day at breakfast and dinner from 03/01/22 to 03/16/22 with results ranging from 88 - 161. Review of the history of FSBS values in the type Brand B glucometer identified for Resident #8 revealed: -The FSBS reading of 159 dated 03/15/22 at 8:10pm did not match the dinner FSBS reading of 96 documented on the Blood Sugar Record and 03/2022 MAR. -There were no FSBS readings of 159 documented on the Blood Sugar Record or 03/2022 MAR for Resident #8. -The FSBS reading of 159 could not be matched to a documented FSBS value for Resident #7 or Resident #8. Interview with an LPN on 03/18/22 at 2:54pm revealed: -She was able to tell which glucometer belonged to Resident #8. -The glucometer strips in the [unlabeled] case were labeled and that was Resident #8's glucometer. -Resident #8's glucometer was not labeled. -Resident #8's glucometer was smaller and in a newer case than the other resident's glucometer. Refer to interview with the Nurse-in-Charge dated 03/17/22 at 2:00pm.	D932			

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NAME OF PROVIDER OR SUPPLIER

CAROLINA INN AT VILLAGE GREEN

STREET ADDRESS, CITY, STATE, ZIP CODE

400 FORSYTHE STREET

FAYETTEVILLE, NC 28303

(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 33 Refer to interview with the Administrator on 03/18/22 at 3:01pm. Refer to interview with the RN Supervisor on 03/18/22 at 3:03pm. Interview with the Nurse-in-Charge on 03/17/22 at 2:00pm revealed: -He understood there could be potential risk for spread of infection with multiple resident use of glucometers. -If there was multiple resident use of glucometers, the glucometers would have to be disinfected between residents. -Each resident in the facility had their own glucometers for use. Interview with the Administrator on 03/18/22 at 3:01pm revealed: -She expected all staff to use each individual resident's glucometer. -She expected each residents glucometer to be labeled. Interview with the RN Supervisor on 03/18/22 at 3:03pm revealed: -She agreed with the Administrator's expectations. -Each resident should have a separate glucometer for finger stick blood sugar monitoring. The facility failed to implement infection control procedures consistent with the Center for Disease Control (CDC) guidelines resulting in the sharing of glucometers between residents which placed residents at risk for possible exposure to bloodborne pathogens diseases. This failure was detrimental to the health, safety and welfare of	D932		

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D932	Continued From page 34 the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/17/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 2, 2022.	D932			