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PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

(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 and the Guilford County Department of Social Services conducted an annual and follow-up survey from February 1, 2023 to February 3, 2023.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff B) who administered medications, had passed the written medication aide exam within 60 days of completing the medication aide competency validation clinical skills checklist. The findings are: Review of Staff B's, medication aide (MA) personnel record revealed:	D 125		

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-Staff B was hired in October 2022.
-There was a certificate of completion dated 10/28/22 for the 15-hour state approved medication aide training for Staff B.
-There was documentation of a medication aide competency validation clinical skills checklist completed for Staff B dated 10/26/22 (timeframe for taking the written MA exam ended on 12/25/22).
-There was no documentation Staff B had successfully passed the written MA exam.

Review of residents' medication administration records for November and December 2022 and January 2023 revealed Staff B documented administration of medications for 2 of 30 days in November 2022; for 3 of 31 days in December 2022; and for 9 of 31 days in January 2023.

Staff B was unavailable for interview on 02/03/23 at 3:32pm.

Interview with the Resident Care Coordinator (RCC) on 02/03/23 3:48pm revealed:
-She was not aware Staff B had not passed the written MA exam within 60 days of completing the medication aide competency validation clinical skills checklist.
-She under the impression Staff B had a 6-month window to pass the written MA exam after completing the medication clinical skills validation checklist.
-Staff B was scheduled to take her written MA exam on 02/07/23.

Interview with the Administrator on 02/03/23 at 02/03/23 at 3:49pm revealed:
-Staff B was hired on 10/22/22.
-She was not aware Staff B had not passed the written MA exam within 60 days of completing the

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D 125	Continued From page 2 medication aide competency validation clinical skills checklist. -She was under the impression that Staff B had a 6-month window to pass the written MA exam after completing the medication aide competency validation clinical skills checklist. -Staff B was scheduled to take the written MA exam on 02/07/23.	D 125		
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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 3 of 7 sampled residents (Residents #5, #9 and #10) with orders for therapeutic diets (pureed and no concentrated sweets diets/NCS) were served as ordered. The findings are: 1. Review of Resident #9's current FL2 dated 01/26/23 revealed: -Diagnoses included oropharyngeal dysphagia and cerebral palsy. -There was an order for a pureed diet.	D 310		

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Review of the diet list posted in the kitchen on 02/01/23 at 10:48am revealed Resident #9 was to be served a pureed diet.

Review of the therapeutic diet menu lunch meal on 02/01/23 for the pureed diets revealed residents ordered a pureed diet should be served: pureed beef patty, pureed fried rice, pureed corn muffin and chocolate pudding.

Observation of Resident #9's lunch meal on 02/01/23 from 12:00pm to 1:00pm revealed:
-A personal care aide (PCA) brought the resident's meal from the kitchen and placed it on the table in front of the resident.
-Resident #9 did not receive feeding assistance.
-Resident #9's meal served was green beans one-half inch in length of green beans that were not pureed.
-Macaroni with ground beef and tomato sauce was on the resident's plate.
-There were identifiable pieces of macaroni and beef with tomato sauce which were ground and not pureed.
-She was served vanilla pudding for dessert.
-Resident #9 consumed 100% of the meal and did not cough or choke.

Interview with the cook on 02/01/23 at 1:09pm revealed:
-She did not puree Resident #9's food, it was pureed by the assistant cook.
-Resident #9 was ordered a pureed diet.
-The resident's meal should be pureed before it left the kitchen.
-She did not observe Resident #9's meal before it was served to the resident.

Interview with the assistant cook 02/01/23 at 1:12pm revealed:

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-He prepared Resident #9's lunch meal.
-The consistency of Resident #9's meal today was the best he could do with the current blender.
-The previous blender "blew up" two weeks ago.
-The Business Office Manager (BOM) got the current blender.
-The blender did not puree the foods smooth.
-He had made the BOM aware the blender was not pureeing correctly but he had not received a better blender.

Interview with the BOM on 02/01/23 at 1:21pm revealed:
-She was not aware Resident #9's meal was not being pureed to the correct consistency.
-The previous brand blender broke and she ordered the identical blender.
-It was going to take six weeks to receive the blender ordered.
-She got the current blender for the cooks to use until the blender ordered arrived.
-She did not know the current blender did not puree foods to a smooth consistency.
-She would try to get a better blender today.

Telephone interview with Resident #9's primary care provider (PCP) on 02/03/23 at 12:08pm revealed:
-When Resident #9 was admitted to the facility she was ordered a pureed diet.
-When she became the PCP for the facility Resident #9 was already ordered a pureed diet, she did not know why.
-Her expectation was the resident's diet should be served as ordered.

Interview with the Administrator on 02/01/23 at 1:31pm revealed:
-She was not aware Resident #9's pureed meal was not prepared to the correct consistency.

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-She was aware the BOM had ordered a new blender that was back ordered and would take six weeks to be delivered.
-She was not aware the current blender did not puree foods to the correct consistency.
-She would take care of the blender issue as soon as possible.

Interview with the Administrator on 02/02/23 at 9:43am revealed:
-The dietary manager (DM) would normally be responsible for observing meals prepared by the cook to ensure diets were served as ordered.
-The current DM had been off work for 12 weeks, and was unable to return to the facility.
-She was in the process of hiring another DM.
-No one else at the facility was responsible for observing meals to ensure diets were served as ordered.

Based on observation, record review and interview on 02/03/23 at 3:10pm it was determined Resident #9 was not interviewable.

2. Review of Resident #10's current FL2 dated 12/08/22 revealed:
-Diagnoses included moderate intellectual disability, hypertension, diabetes mellitus, and anemia.
-There was an order for a pureed diet.

Review of the diet list posted in the kitchen on 02/01/23 at 10:48am revealed Resident #10 was to be served a pureed diet.

Review of the therapeutic diet menu lunch meal on 02/01/23 for the pureed diets revealed residents ordered a pureed diet should be served: pureed beef patty, pureed fried rice, pureed corn muffin and chocolate pudding.

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D 310	Continued From page 6 Observation of Resident #10's lunch meal on 02/01/23 from 12:00pm to 1:00pm revealed: -A personal care aide (PCA) brought the resident's meal from the kitchen and placed it on the table in front of the resident. -The PCA proceeded to feed Resident #10 her meal. -Resident #10's meal served was green beans that were one-half inch in length green beans that were not pureed. -Macaroni with ground beef and tomato sauce was on the resident's plate. There were identifiable pieces of macaroni and beef with tomato sauce which was ground and not pureed. -Vanilla pudding for dessert. -The resident consumed 30% of the meal without difficulty. Interview with the PCA on 02/01/23 at 1:18pm revealed: -Resident #10 was unable to feed herself. -She provided feeding assistance to Resident #10. -Resident #10 never ate much food, she ate a little more than 1/4 of her meal day. -The consistency of Resident #10's meal was not smooth like puree. -Sometimes the consistency of Resident #10's lunch meal today was not pureed smooth, but most times it was pureed smooth. Interview with the cook on 02/01/23 at 1:09pm revealed: -Resident #10 was ordered a pureed meal. -She did not puree Resident #10's food today, it was pureed by the assistant cook. -Resident #10's meal should be pureed to a smooth consistency before it was taken from the kitchen.	D 310		

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-She did not observe Resident #10's meal before it was served to the resident.

Interview with the assistant cook 02/01/23 at 1:12pm revealed:
-He pureed Resident #10's meal today.
-The consistency of Resident #10's meal was the best he could do with the current blender.
-He had made the BOM aware the blender was not pureeing correctly, but he had not received a better blender.
-He was aware it was important to pureed meals to the correct consistency, but he did his best with the blender available.

Telephone interview with Resident #10's primary care provider (PCP) on 02/03/23 at 12:10pm revealed:
-Resident #10 was on hospice and often did not eat her meals.
-Any food the resident ate would need to be pureed.
-It was important that Resident #10's meal was served as ordered and pureed to the correct consistency.
-Her expectation was that Resident #10's meal be served as ordered.

Telephone interview with Resident #10's hospice nurse on 02/03/23 at 3:17pm revealed:
-Resident #10 was ordered a pureed diet.
-She had not observed the meals served Resident #10.
-It would be helpful for the resident's meals to be served as the consistency ordered.

Interview with the Administrator on 02/01/23 at 1:31pm revealed:
-She was not aware Resident #10's pureed meal was not prepared to the correct consistency.

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-She would take care of the blender issue as soon as possible.

Attempted telephone interview with Resident #10's responsible person on 02/03/23 at 2:10pm was unsuccessful.

Based on observation, record review and interview 02/01/23 at 12:40pm, it was determined Resident #10 was not interviewable.

3. Review of Resident #5's current FL2 dated 12/08/22 revealed:
-Diagnoses included diabetes mellitus, hypertension, and dementia.
-There was an order for a no concentrated sweets (NCS) diet.

Review of the diet list posted in the kitchen on 02/01/23 at 10:48am revealed Resident #5 was to be served a NCS diet.

Review of the therapeutic diet menu lunch meal on 02/01/23 for the diets revealed residents ordered a NCS diet should be served: beef patty, fried rice, corn muffin and sugar-free chocolate pudding.

Observation of Resident #5's lunch meal on 02/01/23 from 12:42pm to 1:28pm revealed:
-A personal care aide (PCA) placed the resident's meal on the table in front of the resident.
-Vanilla pudding was served for dessert in a small bowl.
-The resident consumed 75% of the vanilla pudding.

Review of Resident #5's electronic medication administration record for November 2022 revealed that Resident #5's finger stick blood

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sugar (FSBS) range was 75-150.

Review of Resident #5's electronic medication administration record for December 2022 revealed that Resident #5's finger stick blood sugar (FSBS) range was 89-120.

Review of Resident #5's electronic medication administration record for January 2023 revealed that Resident #5's finger stick blood sugar (FSBS) range was 81-155.

Review of nutrition facts on the container of vanilla pudding revealed:
-Four ounces of pudding was considered a serving size.
-There were 12 grams of sugar in a serving of vanilla pudding.

Interview with the PCA on 02/01/23 at 1:12pm revealed he thought that all the facility's desserts were sugar free.

Interview with the cook on 02/02/23 at 8:33am revealed:
-She did not have sugar free pudding to serve residents ordered a NCS diet.
-She served NCS residents regular pudding with sugar.

Interview with the Memory Care Unit Coordinator (MCUC) on 02/03/23 at 11:00am revealed:
-She was aware Resident #5 had an order for a NCS diet.
-She was not aware Resident #5 was served vanilla pudding that was not sugar free during the lunch meal service on 02/01/23.

Interview with the Resident Care Coordinator (RCC) on 02/03/23 at 11:15am revealed:

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D 310	Continued From page 10 -She was aware Resident #5 had an order for a NCS diet. -She was not aware Resident #5 was served vanilla pudding that was not sugar free during the lunch meal service on 02/01/23. Telephone interview with Resident #5's primary care provider (PCP) on 02/03/23 at 11:57am revealed: -Resident #5 had an order for a NCS diet. -She was not aware that Resident #5 was not served a NCS diet as ordered. -Her expectation was that Resident #5's meal be served as ordered. Interview with the Administrator on 02/02/23 at 10:38am revealed she was not aware the cook did not have sugar free pudding to serve residents ordered a NCS diet. Based on observation, record review and interviews, it was determined Resident #5 was not interviewable.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure 1 of 5 sampled residents (Resident #3) were treated with respect, dignity, and consideration related to staff not charging the resident's automatic blood sugar monitoring device and manually sticking the	D 338		

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resident to obtain fingerstick blood sugars (FSBS) which the resident disliked and continually refused to have his FSBS checked.

The findings are:

Review of Resident #3's current FL2 dated 01/05/23 revealed:
-Diagnoses included diabetes mellitus type II, hypertension, hyperlipidemia, peripheral vascular disease, acute kidney failure, history of stroke.
-Resident #3 was intermittently disoriented.
-There was an order for Novolog (fast-acting insulin to control diabetes) flexpen check fingerstick blood sugar (FSBS) before meal and at bedtime and inject per sliding scale insulin (SSI).

Review of Resident #3's physician's order sheet (POS) dated 12/08/22 revealed there was an order to check FSBS before meals and at bedtime and inject per SSI.

Review of Resident #3's Care plan dated 12/06/22 revealed:
-The resident required supervision with eating.
-The resident required assistance with ambulation and transferring.
-The resident required extensive assistance with toileting, dressing and grooming.
-The resident was totally dependent on staff for bathing.
-Resident #3 was to have FSBS completed four times daily and SSI.

Review of Resident #3's Licensed Health Profession Support (LHPS) dated 12/08/22 revealed:
-FSBS were collected and resident refused.
-Medication through injection.

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Review of physician's progress note dated 10/05/22 revealed the physician noted Resident #3 had a freestyle device with reader. The resident stated facility never charged the reader, so staff had to stick him for his blood sugar and "he was sick of getting stuck."

Review of Resident #3's November 2022 electronic medication administration record (eMAR) revealed Resident #3 refused 63 of 120 opportunities for FSBS from 11/01/22 through 11/30/22.

Review of Resident #3's December 2022 eMAR revealed Resident #3 refused 52 of 124 opportunities for FSBS from 12/01/22 through 12/31/22.

Review of Resident #3's January 2023 eMAR revealed Resident #3 refused 72 of 124 opportunities for FSBS from 01/01/23 through 01/31/23.

Review of Resident #3's February 2023 eMAR revealed the resident refused 3 of 4 opportunities for FSBS from 02/01/23 through 02/02/23.

Observation of Resident #3's glucose monitoring system on 02/02/23 at 2:20pm revealed:
-The resident's glucose monitoring device was a brand-named system that automatically sends blood glucose readings directly to a reader that displays the resident's FSBS.
-The system was designed for usage by Resident #3 only.
-The system was not limited to the number of FSBS obtained but was able to record and store FSBS readings for 90 days.
-The reader displayed the number of days usage

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before the battery needed to be charged.

Interview with Resident #3 on 02/03/23 at 11:05am revealed:
-He had a FSBS monitoring device attached to his arm that came with a reader and showed FSBS results.
-A previous staff helped him get the device because he did not like being stuck with a needle and he refused FSBS.
-The device that he had allowed staff to obtain FSBS results without touching him.
-The system was set-up so that staff did not have to stick him with a needle, they got close to his arms and the results popped up on the reader.
-The problem he had was staff did not always charge the reader.
-If the reader was not charged his FSBS would not display on the reader.
-Some days the reader was not charged, and staff had to stick him to obtain his FSBS.
-When staff told him, they were going to stick him to obtain his FSBS result he refused the FSBS because he "hated being when stuck by a needle."

Telephone interview with the manufacturer of the blood glucose monitoring device and reader 02/03/23 at 10:23am revealed:
-The reader was designed for use by the person who had the related device attached to his/her arm.
-The life of the reader was 2 to 3 years.
-The battery of the reader should be fully charged before using.
-To ensure a full charge the reader had to be charged for at least three hours.
-When fully charged the battery of reader lasted seven days.
-The reader displayed the days, and hours left

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before the device had to be charged again.
-The owner/user of the device had to pay attention to the display on the reader to observe when to charge the battery.

Interview with a first shift MA on 02/02/23 at 5:07pm revealed:
-Resident #3 had a glucose monitoring device to obtain FSBS results that did not require her to stick the resident with a needle.
-Some days when she came to work Resident #3's glucose monitoring device reader was not charged and she could not obtain an FSBS result.
-When the reader was not charged, she told Resident #3 that she had to stick him with a needle to manually obtain his FSBS result.
-Resident #3 refused to allow her to stick him to obtain his FSBS because he did not like the needle.
-She usually did not try to charge the reader and later obtain Resident #3's FSBS; she wrote on the eMAR that Resident #3 refused to let her obtain an FSBS result.
-She did not think anyone had been assigned the responsibility of ensuring Resident #2's glucose monitoring reader was fully charged.

Interview with Resident #3's Primary Care Provider (PCP) on 02/02/23 at 11:30am revealed:
-She was aware Resident #3 frequently refused FSBS.
-She was unable or recalled if anyone made her aware the resident's glucose monitoring device reader was not always charged and the resident had to manually be stuck to obtain FSBS results.
-The automatic glucose monitoring device was ordered because Resident #3 did not like to be stuck with a needle and often refused to let staff obtain FSBS using a needle.
-She expected the device to be charged and

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always ready for use, so the resident had to be stuck with a needle.

Interview with the Resident Care Coordinator (RCC) on 02/03/23 at 2:58pm revealed:
-She just learned last week that Resident #3's reader was not being continually charged, and staff had to stick the resident to obtain FSBS results.
-She was not aware about the reader was not being continually charged.
-There was no system in place to ensure the reader was always charged, but she expected staff to charge the reader and ready for use at all times.
-This would be addressed with staff training in the upcoming diabetic training class.

Interview with the Administrator on 02/03/23 at 4:15pm revealed:
-She was aware Resident #3 had an automatic glucose reader and should not be manually stuck with a needle to obtain his FSBS.
-The reader should be charged at all times and ready for use to obtain the resident's FSBS.
-Using the reader Resident #3 did not have to be touched.
-Resident #3 had a right to refuse FSBS, but disagreed Resident #3 had a right to not be stuck with a needle even when staff were aware the resident did not like being stuck with a needle.
-She did not know why the reader was not frequently charged and ready for use.

Attempted telephone interview with a second/third shift MA on 02/02/23 at 4:00pm was unsuccessful.

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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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered during medication administration for 1 of 4 residents related to not administering an anti-anxiety medication (#6) and 2 of 5 sampled residents for record review related to errors with administering sliding scale insulin (#3 and #4). The findings are: 1. Review of Resident #6's current FL2 dated 08/11/22 revealed: -Diagnosis included hypertension and behavioral changes. -There was an order for alprazolam 0.25mg daily (used to treat anxiety). Observation of medication administration on 02/02/23 at 8:05am revealed: -The medication aide (MA) consulted Resident #6's electronic medication administration record (eMAR) for medications to be administered at 8:00am. -The MA prepared 10 oral medications for administration to Resident #6.	D 358		

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-The MA identified alprazolam 0.25mg as not available for administration.
-The MA administered Resident #6's medications (excluding alprazolam) and documented administration for 10 medications for administered and alprazolam for "faxed and called pharmacy to deliver stat".

Review of Resident #6's signed physician's orders dated 12/08/22 revealed an order for alprazolam 0.25mg one tablet once daily.

Review of Resident #6's physician's orders available at the facility revealed:
-There was an order dated 12/13/22 for alprazolam 0.25mg one tablet daily for a quantity of 30 tablets.
-There was an order dated 12/29/22 for alprazolam 0.25mg one tablet daily for a quantity of 30 tablets.

Review of Resident #6's January 2023 eMAR revealed: (Move this above the February review of the MAR)
-The was an entry for alprazolam 0.25mg one tablet once daily scheduled for administration at 7:00am daily.
-Alprazolam 0.25mg was documented for not administered at 7:00am on 01/26/23, 01/27/23, 01/28/23, 01/29/23, 01/30/23 and 01/31/23 (6 days) with the reason documented as "faxed and called pharmacy to deliver stat".

Review of Resident #6's February 2023 eMAR revealed:
-The was an entry for alprazolam 0.25mg one tablet once daily scheduled for administration at 7:00am daily.
-Alprazolam 0.25mg was documented for not administered on 02/01/23 and 02/02/23 with the

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reason documented as "faxed and called pharmacy to deliver stat".

Observation of medication on hand for Resident #6 on 02/02/23 at 8:10am revealed there was not alprazolam 0.25mg on the medication cart or in overstock available for administration.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/02/23 at 2:15pm revealed:
-Alprazolam 0.25mg was not on cycle fill for routinely monthly delivery; the facility was responsible to reorder alprazolam when needed.
-Resident #6's alprazolam 0.25mg was dispensed on 11/25/22 for 30 tablets and on 12/19/22 for 30 tablets.
-There was an order for alprazolam 0.25mg one tablet daily dated 12/29/22 on placed hold at the pharmacy due to a 30 days supply of alprazolam dispensed on 12/13/22.
-There was no facility request for refilling Resident #6's alprazolam showing in the pharmacy's reorder system prior to 02/02/23.

Interview with the Assistant Resident Care Coordinator (ARCC) on 02/02/23 at 2:35pm revealed:
-The MAs were responsible to reorder medications not on cycle fill.
-Resident #6 should not have been out of alprazolam for 8 days.
-The MA reordered residents' medication through the eMAR computer system by clicking a button tab on the medication screen.
-The medication order should be electronically sent to the contracted pharmacy's computer reorder system.
-There was no system in place to routinely audit eMARs for medications awaiting pharmacy

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D 358	Continued From page 19 delivery. Interview with the morning MA on 02/02/23 at 11:30am revealed: -The eMAR system had 4 options for documenting medications not administered that were as follows: out of facility, faxed and called pharmacy to deliver stat, resident refused, and withheld per doctor's order. -She routinely documented "faxed and called pharmacy to deliver stat" when a medication was not available to administer. -She had not called the pharmacy to order Resident #6's alprazolam, but she thought she had reordered the medication at least 2 times through the reorder button (tab) in the eMAR system. -She may have forgotten to call the pharmacy and had not faxed the pharmacy a refill request because she would have waited until she completed her medication passes and a lot of interruptions occurred during a medication pass. Telephone interview with Resident #6's primary care provider (PCP) on 02/02/23 at 12:05pm revealed: -The contracted pharmacy routinely contacts the PCP for alprazolam refills. -She expected the facility to contact her if a resident needed a medication. -Resident #6 had an order dated 12/29/22 that should have been used to provide alprazolam. -The facility was responsible to order medications on a timely basis to prevent the resident from being out of medication. -Resident #6's alprazolam was ordered to help the resident remain calm and decrease anxiety and not receiving the medication could cause increased anxiety or inappropriate behaviors.	D 358		

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D 358	Continued From page 20 Interview with the Administrator on 02/02/23 at 4:00pm revealed: -The MAs were responsible to reorder medications not on cycle fill when the medication was close to running out. -The MA could reorder medications through the computer's reorder system. -She did not know Resident #6 was out of alprazolam for 8 days. -The facility was not currently auditing residents' eMARs for missed doses of medication related to not being available from the pharmacy. Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. 2. Review of Resident #4's current FL2 dated 09/13/22 revealed: -Diagnoses included Type II diabetes mellitus with hyperglycemia. -There was an order to check fingerstick blood sugar (FSBS) before meal and at bedtime. -There was an order for Novolog (fast-acting insulin to control diabetes) flexpen 100units per ml inject per sliding scale insulin (SSI). -There was an order for SSI parameters as follows: less than 121-150= 2 units, 151-200= 3 units, 201-250= 5 units, 251-300= 8 units, 301-350=11 units, 351-400= 15 units, and greater than 400 call physician. Review of Resident #4's physician's order sheet (POS) dated 12/08/22 revealed: -Novolog Flexpen 100units/ml was before meals and at bedtime with the same SSI parameters. -FSBS were ordered 3 times a day, before meals, and at bedtime and scheduled at 7:30am, 11:30am, 4:30pm, and 8:00pm.	D 358		

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D 358	Continued From page 21 Observation of Resident #4's medications on hand at the facility on 02/02/23 at 4:30pm revealed a partial Novolog Flexpen 100u/ml was available for administration. Review of Resident #4's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for check FSBS before each meal and at bedtime and inject Novolog subcutaneously before meals and at bedtime time per SSI scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was entry for SSI parameters as follows: less than 121-150= 2 units, 151-200= 3 units, 201-250= 5 units, 251-300= 8 units, 301-350=11 units, 351-400= 15 units, and greater than 400 call physician. -There were 102 FSBS documented on the eMAR from 11/01/22 through 11/30/22. -The FSBS values ranged from 76 to 283. -Forty-five of the 102 FSBS documented on the November 2022 eMAR were within range for the sliding scale and required insulin administration. -There were 2 errors identified with Novolog Flexpen insulin administration as follows: -On 11/07/22 at 8:00pm, FSBS was 106, 1 unit was documented as administered and should have been given 0 units. -On 11/16/22 at 4:30pm, FSBS was 100, 2 units were documented as administered and should have been given 0 units. Review of Resident #4's December 2022 eMAR revealed: -There was an entry for check FSBS before each meal and at bedtime and inject Novolog insulin subcutaneously before meals and at bedtime time per SSI scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm.	D 358		

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D 358	Continued From page 22 -There was entry for SSI parameters as follows: less than 121-150= 2 units, 151-200= 3 units, 201-250= 5 units, 251-300= 8 units, 301-350=11 units, 351-400= 15 units, and greater than 400 call physician. -There were 101 FSBS documented on the eMAR from 12/01/22 through 12/31/22. -FSBS values ranged from 82 to 283. -Fifty-two of the of 105 FSBS documented on the December 2022 eMAR were within range for the sliding scale and required insulin administration. -There were 9 identified errors for Novolog Flexpen insulin administration with examples as follows: -On 12/05/22 at 4:30pm, FSBS was 137, 4 units were documented as administered and 2 units should have been administered. -On 12/13/22 at 11:30am, FSBS was 137, 0 units were documented as administered and 2 units should have been administered. -On 12/16/22 at 4:30pm, FSBS was 214, 2 units were documented as administered and 5 units should have been administered. -On 12/17/22 at 4:30pm, FSBS was 151, 2 units were documented as administered and 3 units should have been administered. -On 12/22/22 at 4:30pm, FSBS was 283, 2 units were documented as administered and 8 units should have been administered. -On 12/31/22 at 4:30pm, FSBS was 154, 4 units were documented as administered and 3 units should have been administered. Review of Resident #4's January 2023 eMAR revealed: -There was an entry for check FSBS before each meal and at bedtime and inject Novolog insulin subcutaneously before meals and at bedtime time per SSI with scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm.	D 358		

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D 358	Continued From page 23 -There was entry for SSI parameters as follows: less than 121-150= 2 units, 151-200= 3 units, 201-250= 5 units, 251-300= 8 units, 301-350=11 units, 351-400= 15 units, and greater than 400 call physician. -There were 101 FSBS documented on the eMAR from 01/01/23 through 01/31/23. -Fifty-four of the of 101 FSBS documented on the December 2022 eMAR were within range for the sliding scale and required insulin administration. -There were 9 identified errors for Novolog Flexpen insulin administration with examples as follows: -On 01/08/23 at 11:30am, FSBS was 95, 2 units were documented as administered and 0 units should have been administered. -On 01/16/23 at 4:30pm, FSBS was 100, 2 units were documented as administered and 0 units should have been administered. -On 01/20/23 at 8:00pm, FSBS was 172, 2 units were documented as administered and 3 units should have been administered. -On 01/30/23 at 4:30pm, FSBS was 112, 2 units were documented as administered and 0 units should have been administered. Interview with the Executive Director (ED) on 02/02/23 at 4:58pm revealed: -The MAs should administer the correct units of insulin. -There was currently no system in place for routine audits that compared FSBS to units of insulin administered to ensure the units of insulin was accurate. Interview with a medication aide (MA) on 02/02/23 at 9:33am revealed: -After checking a resident's FSBS, she administered the units of insulin based on the sliding scale parameters.	D 358		

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-She was not sure if anyone checked behind her to ensure the units of insulin administered was accurate according to SSI parameters.

Telephone interview with Resident #4's primary care provider (PCP) on 02/03/23 at 12:05pm revealed:
-She expected Resident #4's Novolog insulin to be administered accurately according to the ordered sliding scale in order to maintain blood sugar control.

Interview with the Resident Care Coordinator (RCC) on 02/03/23 at 1:40pm revealed:
-The facility did not have a system of comparing units of insulin administered with FSBS results.
-No one reviewed the units of insulin documented on the eMARs to ensure the units administered were accurate according to the sliding scale.
-She expected all residents' insulins to be administered as ordered.

Interview with Resident #4 on 02/03/23 at 3:55pm revealed:
-Staff routinely checked her FSBS.
-She knew she should not receive insulin if her FSBS was below 100.
-She was not sure what the reading were all the time.
-She had not experienced any episodes when she was sweating or dizzy like she felt when her blood sugar was low.

Attempted telephone interview with a first shift MA that made errors with insulin administration on 02/02/23 at 3:58pm was unsuccessful.

3. Review of Resident #3's current FL2 dated 01/05/23 revealed:
-Diagnoses included diabetes mellitus type II,

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hypertension, hyperlipidemia, peripheral vascular disease, acute kidney failure, history of stroke.
-There was an order for Novolog (fast-acting insulin to control diabetes) flexpen check fingerstick blood sugar (FSBS) before meal and at bedtime and inject per sliding scale insulin (SSI).
-There were no parameters for the SSI on the FL2.

Review of Resident #3's physician's order sheet (POS) dated 12/08/22 revealed there was an order for Novolog flexpen, check FSBS before meals and at bedtime and inject per SSI: less than 200=0 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 201-450=12 units, greater than 451=14 units and call physician.

Observation of Resident #3's medications on hand at the facility on 02/02/23 at 2:20pm revealed Novolog was available for administration.

Review of Resident #3's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog before meals and at bedtime time inject per SSI scheduled at 7:00am, 11:30am, 4:30pm and 8:00pm.
-There were 54 FSBS documented on the eMAR from 11/01/22 through 11/30/22.
-Thirty-five of the of 54 FSBS documented on the November 2022 eMAR were within range for the sliding scale and required insulin administration.
-There were four errors identified with insulin administration as follows:
-On 11/01/22 at 7:00am, FSBS was 201, units documented as administered was 0 units and should have been given 4 units.

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D 358	Continued From page 26 -On 11/20/22 at 11:30am, FSBS was 245, units documented as administered was "4245", units and should have been given 4 units. -On 11/30/22 at 7:00am, FSBS was 343, units documented as administered was 10 units and should have been given 8 units. -On 11/30/22 at 11:30am, FSBS was 343, units documented as administered was 10 units and should have been given 8 units. Review of Resident #3's December 2022 eMAR revealed: -There was an entry for Novolog before meals and at bedtime time inject per SSI scheduled at 7:00am, 11:30am, 4:30pm and 8:00pm. -There were 75 FSBS documented on the eMAR from 12/01/22 through 12/31/22. -Forty-six of the of 75 FSBS documented on the December 2022 eMAR were within range for the sliding scale and required insulin administration. -There were 13 identified errors with insulin administration as follows: -On 12/05/22 at 8:00pm, FSBS was 190, units documented as administered was 6 units and should have been given no SSI. -On 12/06/22 at 11:30am, FSBS was 201, units documented as administered was 6 units and should have been given 4 units. -On 12/10/22 at 4:30pm, FSBS was 142, units documented as administered was 4 units and should have been given no SSI. -On 12/14/22 at 4:30pm, FSBS was 238, units documented as administered was "238" units and should have been given 4 units. -On 12/16/22 at 4:30pm, FSBS was 307, units documented as administered was 6 units and should have been given 8 units. -On 12/17/22 at 7:00am, FSBS was 234, units documented as administered was 2 units and should have been given 4 units.	D 358		

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D 358	Continued From page 27 -On 12/17/22 at 11:30am, FSBS was 141, units documented as administered was 2 units and should have been given no SSI. -On 12/17/22 at 4:30pm, FSBS was 181, units documented as administered was 2 units and should have been given no SSI. -On 12/20/22 at 7:00am, FSBS was 301, units documented as administered was 6 units and should have been given 8 units. -On 12/28/22 at 7:00am, FSBS was 340, units documented as administered was 10 unit and should have been given 8 units. -On 12/28/22 at 11:30am, FSBS was 340, units documented as administered was 10 units and should have been given 8 units. -On 12/29/22 at 11:30am, FSBS was 142, units documented as administered was 2 units and should have been given no SSI. -On 12/29/22 at 4:30pm, FSBS was 243, units documented as administered was 8 units and should have been given 4 units. Review of Resident #3's January 2023 eMAR revealed: -There was an entry for Novolog before meals and at bedtime time inject per SSI scheduled at 7:00am, 11:30am, 4:30pm and 8:00pm. -There were 43 FSBS documented on the eMAR from 01/01/23 through 01/31/23. -Thirty-two of the of 75 FSBS documented on the January 2023 eMAR were within range for the sliding scale and required insulin administration. -There were four identified errors with insulin administration per sliding scale with as follows: -On 01/02/23 at 4:30pm, FSBS was 201, units documented as administered was 6 units and should have been given 4 units. -On 01/06/23 at 7:00am, FSBS was 120, units documented as administered was 1 units and should have been given no SSI.	D 358		

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D 358	Continued From page 28 -On 01/15/23 at 7:00am, FSBS was 321, units documented as administered was 6 units and should have been given 8 units. -On 01/30/23 at 4:30pm, FSBS was 290, units documented as administered was 8 units and should have been given 6 units. Interview with Resident #3 on 02/03/23 at 10:50am revealed: -He was a diabetic and the medication aide (MA) checked his FSBS before meals and in the evening. -Insulin was administered, but he was unaware of the units of insulin administered. Interview with the MA on 02/02/23 at 9:33am revealed: -Resident #3 was administered Novolog insulin based on the sliding scale ordered. -She was not sure of the FSBS range for administered Novolog without looking at the sliding scale. -After checking Resident #3's FSBS, she administered the units of Novolog based on what was on the sliding scale. -After administering Novolog she documented the units of insulin administered on the eMAR. -She was not sure if anyone checked behind her to ensure the units of Novolog administered was accurate. Interview with the Executive Director (ED)on 02/02/23 at 4:58pm revealed: -The MAs should administer the correct units of insulin. -There was currently no system in place for routine audits that compared FSBS to units of insulin administered to ensure the units of insulin was accurate.	D 358		

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D 358	Continued From page 29 Telephone interview with Resident #3's primary care provider (PCP) on 02/03/23 at 11:50am revealed: -She expected Resident #3's insulin to be administered ordered. -She expected the MAs to administer the Novolog accurately according to the ordered sliding scale. Interview with the Resident Care Coordinator (RCC) on 02/03/23 at 1:40pm revealed: -The facility did not have a system of comparing units of insulin administered with FSBS results. -No one reviewed the units of insulin documented on the eMAR to ensure the units administered were accurate according to the sliding scale. -She expected Resident #3's Novolog to be administered as ordered. Attempted telephone interview with a first shift MA that made errors with units of insulin administered on 02/02/23 at 3:58pm was unsuccessful. Attempted telephone interview with a second shift MA that made errors with units of insulin administered on 02/03/23 at 10:58am was unsuccessful.	D 358		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration.	D 378		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure all prescription and non-prescription medications stored by the facility were maintained under locked security except when under the direct physical supervision of staff in charge of medication administration.

The findings are:

Review of the facility's current license effective January 1, 2023 revealed the facility was licensed for a capacity of 93 with 24 Special Care Unit (SCU) beds.

Review of the facility's resident census report dated 02/02/23 revealed there was a census of 65 residents.

Observation of the entry foyer on 02/02/23 from 7:35am to 9:55am revealed:
-At 7:35am, beside and to the right of the front entry door, there were 3 gray pharmacy medication totes stacked on top of each other.
-There was an office (concierge) area to the left of the front door past the entrance top the dining room.
-There were no staff seated at the front concierge desk.
-The gray totes contained partial medication bubble packs and bulk containers and were not sealed with any type of security.
-There were "Drug returned to pharmacy or released to the patient log sheets" in the totes listing medications being returned.
-Review of one of the drug return sheets revealed medications being returned included Vitamin D 1000 (used to supplement vitamin deficiency), melatonin 5mg (used to treat insomnia), cetirizine 10mg (used to treat allergies), aspirin 81mg

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(used to thin blood), acetaminophen 500mg (used to treat pain/fever).
- Review of a second drug return sheet revealed medications being returned included levothyroxine 0.175mg (used to treat thyroid insufficiency), pantoprazole 20mg (used to treat acid reflux), fluoxetine 20mg (used to treat depression), amlodipine 5mg (used to treat high blood pressure).
-Review of a third drug return sheet revealed medications being returned included vitamin d, aspirin 81mg, daily vitamin (used to supplement vitamin intake), and ferrous sulfate (used to supplement iron deficiency).
-At 7:50am, there were 15 to 20 residents seated in the large gathering room across from the dining room entrance and near the front entrance door. There was no staff visible that was in sight of the medication totes.
-At 8:40am, a resident was observed in the hallway leaving the dining room with the medication totes 20 feet behind the resident. --
-There was no staff visible that was in sight of the medication totes.
-At 8:45am, the concierge staff walked past the gray totes on her way to the concierge office.
-At 8:48am, a resident came from the dining room and walked across the hall to the large sitting room, within 20 feet of the gray totes.
-At 9:00am, the Administrator moved the gray totes to a secure location.
-At 9:55am, a delivery van was observed outside the building and the driver was placing the gray totes in the van.

Interview with the concierge staff on 02/02/23 at 8:48am revealed:
-The gray totes were medication totes used by the pharmacy to deliver medications and the facility to return medications

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-The gray totes probably contained residents' medications being returned to the pharmacy that were replaced with the current cycle fill medications.
-She had not routinely seen the totes sitting by the front door and was not responsible for monitoring the totes.

Interview with the Administrator on 02/02/23 at 8:50am revealed:
-The gray totes were pharmacy totes and contained residents' medications returned to the pharmacy after the current cycle fill medications were placed on the medication carts.
-There were no controlled medications returned to the pharmacy because the controlled medications were sent in red sealed totes.

Interview with a first shift MA on 02/02/23 at 8:53am revealed:
-The third shift MA supervisor was responsible to switch out the cycle fill medications and process the returned medications.
-She had not noticed the gray totes at the front door area this morning when she assisted residents in the dining room.
-The gray pharmacy totes were usually locked up in the medication rooms until the pharmacy driver called to say he was coming to pick up returns.

Second interview with the Administrator on 02/02/23 at 8:55am revealed:
-The third shift medication aide (MA) was responsible for replacing residents' medications with the new cycle fills and sending the medications removed from the medication carts back to the pharmacy. The returned medications were logged on the "Drug returned to pharmacy or released to the patient log sheets".
-Routinely, the gray medication return totes were

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D 378	Continued From page 33 stored in the locked medication storage rooms until the pharmacy delivery truck came to the facility to pick up the totes. -Today, the pharmacy delivery driver had been delayed in his pick-up. -Apparently the third shift MA brought the gray totes to the front door and left before the driver picked up the totes. Telephone interview with the Director of the facility's contracted pharmacy provider revealed: -The pharmacy return policy was medications to be returned should be listed on the pharmacy return sheet. -The medications should be placed in the gray pharmacy totes, if not controlled drugs, and secured until the pharmacy driver picked the medications up at the facility. Interview with the Assistant Resident Care Coordinator on 02/02/23 at 2:55pm revealed: -The facility policy was staff were to complete the pharmacy drug return log and placed residents' medication in the gray pharmacy totes along with the paperwork. -The gray pharmacy totes were supposed to remain locked up in the medication storage room until the driver notified the facility that he was at the facility to pick up the totes.	D 378		
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 infectious diseases, each adult care home shall do all of the following:	D932		

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D932	Continued From page 34 (1) Implement written infection prevention and control policies and procedures that are based on accepted national standards consistent with the federal Centers for Disease Control and Prevention guidelines on infection control, which shall be maintained in the facility and accessible to adult care home staff working at the facility. The policies and procedures shall address 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 resident 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.	D932		

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D932	Continued From page 35 g. Standard and transmission-based precautions, including the following: 1. Respiratory hygiene and cough etiquette. 2. Environmental cleaning and disinfection. 3. Reprocessing and disinfection of reusable resident devices. 4. Hand hygiene. 5. Accessibility and proper use of personal protective equipment. 6. Types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions. h. In accordance with the public health laws of North Carolina, when and how to report to the local health department a suspected or confirmed, reportable communicable disease case or condition, or a communicable disease outbreak. i. Procedures for ensuring that residents, representatives of residents, and adult care home staff are informed of the following without disclosing any personally identifiable information of the facility's residents or staff: 1. The existence of a communicable disease outbreak within 24 hours following confirmation of the outbreak by the local health department. 2. When the communicable disease outbreak has resolved. 3. Any changes to facility operations during the communicable disease outbreak, such as visitation policy changes. j. Measures the facility should consider for	D932		

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D932	Continued From page 36 specific types of communicable disease outbreaks in order to prevent the spread of illness, such as: 1. Isolating infected residents. 2. Limiting or stopping group activities and communal dining. 3. Limiting or restricting outside visitation to the facility. 4. Screening staff, residents, and visitors for signs of illness. 5. Using source control as tolerated by the residents. k. Strategies for addressing potential staffing issues and ensuring adequate staffing is available to meet the needs of the residents during a communicable disease outbreak. (2) Require and monitor compliance with the facility's infection prevention and control policies and procedures. (3) Update the infection prevention and control policies and procedures as necessary to maintain consistency with accepted national standards in infection prevention and control. (4) Designate one on-site staff member for each noncontiguous facility who is knowledgeable about the federal Centers for Disease Control and Prevention guidelines on infection control to direct the facility's infection control activities and ensure that all adult care home staff is trained in the facility's written infection prevention and control policies and procedures developed pursuant to subdivision (b)(1) of this section within 30 days after hire and annually thereafter. Any nonsupervisory	D932		

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D932	Continued From page 37 staff member designated to direct the facility's infection control activities shall complete the infection control course developed by the Department pursuant to G.S. 131D-4.5C. (5) When a communicable disease outbreak has been identified at a facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's infection control and prevention policies and procedures developed pursuant to subdivision (b)(1) of this section and related policies and procedures; section; provided, however, that if guidance or directives specific to a communicable disease outbreak or emerging infectious disease threat have been issued in writing by the Department or local health department, the Department's or local health department's specific guidance or directives shall be implemented by the facility. Effective January 1, 2022 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 (#3, #7, and #8) with orders for blood sugar monitoring resulting in	D932		

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D932	Continued From page 38	D932		

shared glucometers between residents.

The findings are:

Observation of fingerstick blood sugar (FSBS) testing on the 100 Hall by a morning medication aide (MA) on 02/02/23 at 10:50am revealed:
-The medication aide (MA) removed a black zipper storage pouch labeled with a resident's name from the lower drawer of the medication cart. The zippered pouch did not have a glucometer in the pouch.
-The MA opened the top left drawer of the medication cart and located a Brand A glucometer laying in the drawer; the glucometer was not labeled with a resident's name.
-The MA placed the Brand A glucometer in the zippered pouch labeled with a resident's name.
-The MA donned gloves and used proper infection prevention techniques to obtain the FSBS.
-The MA disposed of the single use lancing device and test strip in a biohazard waste container and the gloves and alcohol swabs in the trash.
-The MA returned the Brand A glucometer to the pouch labeled with a resident's name, and zipped the pouch.
-There was no observation of cleaning/disinfecting the glucometer before or after use.

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

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information, the glucometer should not be shared between residents.

Telephone interview with a customer service representative for the Brand A glucometer on 02/02/23 at 2:10pm revealed related to cleaning and disinfecting instructions for the Brand A glucometer revealed the glucometer was intended to be used by a single person and should not be shared.

Review of the facility's Infection Control/ Universal Precautions Policy (no date indicated) revealed the policy did not contain information regarding the procedure for checking fingerstick blood sugars (FSBS) or the use of glucometers.

Interview with the Executive Director (ED) on 02/02/23 at 2:00pm revealed the facility policy for glucometer use was all residents receiving FSBS to have their own glucometer.

1. Review of Resident #7's current FL2 date 01/26/23 revealed:
-Diagnoses included schizoaffective disorder and diabetes mellitus.
-There was an order for fingerstick blood sugar (FSBS) (frequency not listed).

Review of Resident #7's physician orders dated 12/08/22 revealed an order to check FSBS two times daily.

Observation of the 100 hall medication cart on 02/02/23 at 10:40am revealed:
-Resident #7 had a black zippered pouch labeled with her name, but no glucometer in the pouch.
-The MA located a Brand A glucometer in a top drawer of the medication cart and placed it in Resident #7's pouch.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

(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 40 -There was no resident's name on the Brand A glucometer. Review of FSBS values recorded in the history of the Brand A glucometer identified as Resident #7's glucometer revealed: -The date and time on the glucometer were set correctly. -FSBS values recorded in the history of the glucometer from 01/11/23 to 02/02/23 were not consistent with FSBS readings documented on the resident's January 2023 and February 2023 electronic medication administration records (eMARs). Review of Resident #7's January 2023 eMAR revealed: -There was an entry for FSBS checks two times a day scheduled at 6:30am and 4:00pm daily. -FSBS values were documented on the eMAR 2 times a day from 01/11/23 to 01/31/23. Review of FSBS values recorded in the history of Resident #7's glucometer compared to the FSBS values documented on the January 2023 eMAR revealed: -There were 42 opportunities for FSBS values documented on the eMAR from 01/11/23 to 01/31/23. -There were 57 FSBS values recorded in the history of Resident #7's glucometer from 01/11/23 to 01/31/23 with 11 FSBS values recorded in the history of the glucometer that matched FSBS values and 46 FSBS values recorded in the history of the glucometer that did not match FSBS values documented on the January 2023 eMAR. -There were multiple FSBS readings within a short period of time recorded in Resident #7's glucometer's history on 01/11/23, 01/24/23, 01/25/23, 01/26/23, 01/27/23, 01/28/23, 01/29/23,	D932		

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D932	Continued From page 41 01/30/23, and 01/31/23. Review of additional values recorded in the history of Resident #7's glucometer in a short period of time and not documented on Resident #7's January 2023 eMAR revealed: -On 01/11/23 at 8:19am, the FSBS was 140 and no matching FSBS documented on the eMAR; at 8:24am, the FSBS was 430 and documented on Resident #7's eMAR; at 8:28am, the FSBS was 73 and no matching FSBS documented on the eMAR. -On 01/26/23 at 8:03am, the FSBS was 130,; at 8:06am, the FSBS was 347, and at 8:19am the FSBS was 104 and none of the FSBS values matched the FSBS of 357 documented at 6:30am on Resident #7's eMAR. -On 01/28/23 at 6:40am, the FSBS was 328 recorded in the history of Resident #7's glucometer and documented on the resident's eMAR; at 12:22pm, the FSBS of 384 was recorded in the history of Resident #7's glucometer but not documented on the resident's eMAR and was consistent with FSBS reading documented on another resident's (#3) eMAR. Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/23 at 12:20pm revealed: Refer to the interview with the Executive Director (ED) on 02/02/23 at 4:58pm. Refer to the interview with a medication aide (MA) on 02/02/23 at 5:10pm. Refer to the interview with a second MA on 02/03/23 at 10:20am. Refer to the telephone interview with the facility's	D932		

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D932	Continued From page 42 contracted primary care provider (PCP) on 02/03/23 at 12:05pm. 2. Review of Resident #8's current FL2 date 03/24/22 revealed diagnoses included spinal stenosis and diabetes mellitus type 2 Review of Resident #8's physician orders dated 12/01/22 revealed an order to check FSBS daily at 8:00am. Observation of the 100 hall medication cart on 02/02/23 at 10:40am revealed: -There was a black zippered pouch labeled with Resident #8's name and Brand A glucometer inside the zipped pouch. -There was no resident's name on the Brand A glucometer. Review of FSBS values recorded in the history of the Brand A glucometer identified by the morning medication aide (MA) as Resident #8's glucometer revealed: -The date on the glucometer was set correctly. -The time on the glucometer was not set correctly. -FSBS values recorded in the history of the glucometer from 01/11/23 to 02/02/23 were not consistent with FSBS readings documented on the resident's January 2023 and February 2023 electronic medication administration records (eMARs). Review of Resident #8's January 2023 eMAR revealed: -There was an entry for FSBS daily scheduled at 8:00am daily. -FSBS values were documented on the eMAR daily from 01/11/23 to 01/31/23.	D932		

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D932	Continued From page 43 Review of FSBS values recorded in the history of Resident #8's glucometer compared to the FSBS values documented on the January 2023 eMAR revealed: -There were 21 opportunities for FSBS values documented on the eMAR from 01/11/23 to 01/31/23. -There were 7 FSBS values recorded in the history of Resident #8's glucometer from 01/11/23 to 01/31/23 with 5 FSBS values recorded in the history of the glucometer that matched FSBS values and 2 FSBS values recorded in the history of the glucometer that did not match FSBS values documented on the January 2023 eMAR. -There were no FSBS values documented in the history of Resident #8's glucometer on 01/11/23, 01/14/23, 01/15/23, 01/17/23, 01/19/23 to 01/22/23, 01/24/23 to 01/31/23, and 02/01/23 to 02/02/23 with FSBS values documented on the January 2023 eMAR. -On 01/27/23 at 8:00am, there was a FSBS value of 58 documented on the eMAR and not documented in the history of the glucometer with an extra FSBS value corresponding to the same time and date in Resident #7's glucometer. -On 01/29/23 at 8:00am, there was a FSBS value of 103 documented on the eMAR and not documented in the history of the glucometer with an extra FSBS value corresponding to the same time and date in Resident #7's glucometer. -On 01/30/23 at 8:00am, there was a FSBS value of 126 documented on the eMAR and not documented in the history of the glucometer with an extra FSBS value corresponding to the same time and date in Resident #7's glucometer. Review of Resident #8's February 2023 eMAR revealed: -There was an entry for FSBS daily scheduled at 8:00am daily.	D932		

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D932	Continued From page 44 -FSBS values were documented on the eMAR daily on 02/01/23 and 02/02/23. Review of FSBS values recorded in the history of Resident #8's glucometer compared to the FSBS values documented on the February 2023 eMAR revealed: -There were 1 opportunity for FSBS values documented on the eMAR on 02/01/23. -There were no FSBS values recorded in the history of Resident #8's glucometer for 02/01/23. -On 02/01/23 at 8:00am, there was a FSBS value of 72 documented on the eMAR and not documented in the history of the glucometer with an extra FSBS value corresponding to the same time and date in Resident #7's glucometer. Interview with Resident #8 on 02/02/23 at 4:30pm revealed: -MAs obtained his FSBS checks everyday. -The MAs brought a glucometer that looked the same each time to check his FSBS, but he did not know if the glucometer had his name on it. Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/23 at 12:20pm revealed: Refer to the interview with the Executive Director (ED) on 02/02/23 at 4:58pm. Refer to the interview with a medication aide (MA) on 02/02/23 at 5:10pm. Refer to the interview with a second MA on 02/03/23 at 10:20am. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 02/03/23 at 12:05pm.	D932		

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D932	Continued From page 45 3. Review of Resident #3's current FL2 dated 01/05/23 revealed: -Diagnoses included diabetes mellitus type II, hypertension, hyperlipidemia, peripheral vascular disease, acute kidney failure, history of stroke. -There was an order for Novolog (fast-acting insulin to control diabetes) flexpen check fingerstick blood sugar (FSBS) before meal and at bedtime and inject per sliding scale insulin (SSI). -There were no parameters for the SSI on the FL2. Review of Resident #3's physician's order sheet (POS) dated 12/08/22 revealed there was an order for Novolog flexpen, check FSBS before meals and at bedtime and inject per SSI: less than 200=0 units (U), 201-250=4U, 251-300=6U, 301-350=8U, 351-400=10U, 201-450=12U, greater than 451=14U and call physician. Observation of Resident #3's glucose monitoring system on 02/02/23 at 2:20pm revealed: -The resident's glucose monitoring was a brand-named system that automatically sent glucose readings directly to a reader that displayed the resident's FSBS. -The system was designed for usage for only Resident #3. -The system was not limited to the number of FSBS obtained but was able to record and store FSBS readings for 90 days. Review of Resident #3's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS before meals and at bedtime time and inject per SSI scheduled at 7:30am, 11:30am, 4:30pm and 7:00pm.	D932		

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D932	Continued From page 46 -There was opportunity to obtain 120 FSBS at 7:30am, 11:30am, 4:30pm and 7:00pm from 11/01/22 through 11/30/22. -There were 54 FSBS documented on the eMAR from 11/01/22 through 11/30/22. -Twenty-four of the of 54 FSBS values documented on the November 2022 eMAR were not recorded in the resident's glucose monitoring reader history with examples as follows: -On 11/01/22 at 7:30am, FSBS was 201, and not in the resident's glucose monitoring reader history. -On 11/05/22 at 7:00pm, FSBS was 228, and not in the resident's glucose monitoring reader history. -On 11/18/22 at 7:00pm, FSBS was 350, and not in the resident's glucose monitoring reader history. -On 11/21/22 at 4:30pm, FSBS was 260, and not in the resident's glucose monitoring reader history. -On 11/23/22 at 4:30pm, FSBS was 202, and not in the resident's glucose monitoring reader history. -On 11/24/22 at 4:30pm, FSBS was 205, and not in the resident's glucose monitoring reader history. -On 11/24/22 at 7:00pm, FSBS was 287, and not in the resident's glucose monitoring reader history. -On 11/28/22 at 7:00pm, FSBS was 210, and not in the resident's glucose monitoring reader history. -On 11/30/22 at 7:30am, FSBS was 343, and not in the resident's glucose monitoring reader history. -On 11/30/22 at 11:30am, FSBS was 343, and not in the resident's glucose monitoring reader history.	D932		

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D932	Continued From page 47 Review of Resident #3's December 2022 eMAR revealed: -There was an entry for FSBS before meals and at bedtime time and inject per SSI scheduled at 7:30am, 11:30am, 4:30pm and 7:00pm. -There was opportunity to obtain 124 FSBS at 7:30am, 11:30am, 4:30pm and 7:00pm from 12/01/22 through 12/31/22. -There were 75 FSBS documented on the eMAR from 12/01/22 through 12/31/22. -Twenty-one of the of 75 FSBS documented on the December 2022 eMAR were not recorded in the resident's glucose monitoring reader history with examples as follows: -On 12/01/22 at 7:30am, FSBS was 321, and not in the resident's glucose reader history. -On 12/10/22 at 7:30am, FSBS was 300, and not in the resident's glucose reader history. -On 12/14/22 at 11:30am, FSBS was 204, and not in the resident's glucose reader history. -On 12/15/22 at 7:30am, FSBS was 273, and not in the resident's glucose reader history. -On 12/15/22 at 4:30pm, FSBS was 234, and not in the resident's glucose reader history. -On 12/16/22 at 11:30am, FSBS was 273, and not in the resident's glucose reader history. -On 12/17/22 at 7:30am, FSBS was 234, and not in the resident's glucose reader history. -On 12/19/22 at 7:30am, FSBS was 278, and not in the resident's glucose reader history. -On 12/19/22 at 11:30am, FSBS was 254, and not in the resident's glucose reader history. -On 12/19/22 at 4:30pm, FSBS was 236, and not in the resident's glucose reader history. -On 12/20/22 at 7:30am, FSBS was 201, and not in the resident's glucose reader history. -On 12/20/22 at 11:30am, FSBS was 268, and not in the resident's glucose reader history. -On 12/23/22 at 7:30am, FSBS was 277, and not in the resident's glucose reader history.	D932		

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D932	Continued From page 48 Review of Resident #3's January 2023 eMAR revealed: -There was an entry for FSBS before meals and at bedtime time and inject per SSI scheduled at 7:30am, 11:30am, 4:30pm and 7:00pm. -There was opportunity to obtain 124 FSBS at 7:30am, 11:30am, 4:30pm and 7:00pm from 01/01/23 through 01/31/23. -There were 43 FSBS documented on the eMAR from 01/01/23 through 01/31/23. -Twenty-five of the of 43 FSBS documented on the January 2023 eMAR were not recorded in the resident's glucose monitoring reader history with examples as follows: -On 01/02/23 at 7:30am, FSBS was 303, and not in the resident's glucose reader history. -On 01/02/23 at 11:30am, FSBS was 292, and not in the resident's glucose reader history. -On 01/02/23 at 4:30pm, FSBS was 201, and not in the resident's glucose reader history. -On 01/08/23 at 7:30am, FSBS was 250, and not in the resident's glucose reader history. -On 01/08/23 at 11:30am, FSBS was 245, and not in the resident's glucose reader history. -On 01/08/23 at 4:30pm, FSBS was 277, and not in the resident's glucose reader history. -On 01/10/23 at 4:30pm, FSBS was 255, and not in the resident's glucose reader history. -On 01/15/23 at 7:30am, FSBS was 321, and not in the resident's glucose reader history. -On 01/15/23 at 11:30am, FSBS was 298, and not in the resident's glucose reader history. -On 01/15/23 at 4:30pm, FSBS was 265, and not in the resident's glucose reader history. -On 01/16/23 at 11:30am FSBS was 301, and not in the resident's glucose reader history. -On 01/16/23 at 4:30pm, FSBS was 277, and not in the resident's glucose reader history. -On 01/20/23 at 7:30am, FSBS was 251, and not	D932		

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D932	Continued From page 49	D932		

in the resident's glucose reader history.
-On 01/20/23 at 11:30am, FSBS was 204, and not in the resident's glucose reader history.
-On 01/20/23 at 4:30pm, FSBS was 251, and not in the resident's glucose reader history.
-On 01/22/23 at 11:30am, FSBS was 210, and not in the resident's glucose reader history.
-On 01/22/23 at 4:30pm, FSBS was 201, and not in the resident's glucose reader history.
-On 01/24/23 at 4:30pm, FSBS was 282, and not in the resident's glucose reader history.
-On 01/27/23 at 11:30am, FSBS was 331, and not in the resident's glucose reader history.
-On 01/28/23 at 11:30am,, FSBS was 384, and not in the resident's glucose reader history.
-On 01/28/23 at 4:30pm, FSBS was 244, and not in the resident's glucose reader history.

Observation of Resident #3's glucose monitoring device on the medication cart at the facility on 02/02/23 at 2:20pm revealed:
-Resident #3 had a brand-name glucose monitoring device reader.
-There was no glucometer on the medication cart with Resident #3's name.
-There were several glucometers on the medication cart.
-Some of the glucometers were in black cloth pouches and some glucometers were loose in the cart.
-There were three pouches without a resident's name listed.
-Three of the glucometers observed in the medication cart did not have a resident's name listed to identify the resident who the glucometer belonged to.

Observation of FSBS readings recorded in another resident's glucometer on 02/02/23 at 11:23am revealed:

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D932	Continued From page 50 -Three FSBS documented on Resident #3's eMAR corresponded with FSBS readings on the same date and time in another resident's glucometer as follows: -On 01/27/23 at 11:30am, the FSBS was 331. -On 01/28/23 at 11:30am, the FSBS was 384. -On 01/28/23 at 4:30pm, the FSBS was 244. Based on review of FSBS values documented on Resident #3's November and December 2022, and January 2023 eMAR and FSBS recorded in the resident's glucose monitoring reader history for November and December 2022, and January 2023, the FSBS documented on the eMAR did not match FSBS obtained using the resident's glucose monitoring reader history. Interview with Resident #3 on 02/03/23 at 10:50am revealed: -He was a diabetic and his FSBS was checked four times daily. -He had a device attached to the backside of his right arm that was for obtaining FSBS readings. -He had the monitoring device on his arm in place since the summer 2022 (not sure of the exact day the device was placed on his arm). -Some days, the medication aide (MA) told him the reader to the monitoring device was not charged and she had to stick him to obtain his FSBS. -The MA had a glucometer with her, but he did not pay attention to the glucometer and was not sure if his name was on the glucometer. -He did not know if the same glucometer was used each time the MA manually obtained his FSBS. -The MA would stick his finger and obtain his blood using a plastic strip. -The MA put the plastic strip in the glucometer and the results came out.	D932		

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D932	Continued From page 51 -He did not like having his finger stuck and most days he refused to let the MA check his FSBS. Interview with the first shift MA on 02/02/23 at 9:33am revealed: -Resident #3 had an automatic monitoring device on the backside of his right arm. -Most days the reader to obtain the resident's FSBS readings was not charged. -She did not know who, if anyone was responsible for charging Resident #3's monitoring device reader. -When the FSBS reader was not charged, she had to manually obtained the resident's FSBS by sticking his finger, obtaining the blood using a glucometer strip, and inserting the strip into a glucometer. -Most days of the week, the FSBS reader was not charged, and she had to obtain the resident's FSBS manually using a glucometer. -She started working at the facility as a contracted MA in July 2022 and was trained to check Resident #3's FSBS using a glucometer when the resident's reader was not charged. -When asked what glucometer was used to manually obtain Resident #3's FSBS the MA stated Resident #3 did not have an assigned glucometer. Interview with the first shift MA on 02/02/23 at 2:24pm (that documented FSBS on 01/27/23 and 01/28/23) revealed: -Resident #3 did not have his own glucometer on the medication cart. -The resident had a device that was supposed to automatically check the resident's FSBS. -Most times when she worked, the FSBS reader used to obtain Resident #3's FSBS was not charged. -When the FSBS reader was not charged, she	D932		

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	HAL041010	A. BUILDING: _____ B. WING _____	R 02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

(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 52 had to manually check the resident's FSBS. -When asked for Resident #3's glucometer, the MA replied "Resident #3 did not have a glucometer." -When asked how she obtained the resident's FSBS without an assigned glucometer, the MA hunched both of her shoulders in an upward motion and did not respond. -When asked to see the glucometer used to check Resident #3's FSBS, the MA stated again "Resident #3 did not have a glucometer." Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/23 at 12:20pm revealed: Refer to the interview with the Executive Director (ED) on 02/02/23 at 4:58pm. Refer to the interview with a medication aide (MA) on 02/02/23 at 5:10pm. Refer to the interview with a second MA on 02/03/23 at 10:20am. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 02/03/23 at 12:05pm. _____ Interview with the RCC on 02/02/23 at 12:20pm revealed: -Each resident should have a glucometer assigned to the residents. -The glucometer and the zipper pouch should be labeled with matching resident names. -MAs were trained to label glucometers and use only the glucometer assigned to a resident. -She did not know MAs were sharing glucometers between residents. -She had not conducted an audit of the	D932		

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D932	Continued From page 53	D932		

medication carts to ensure glucometers assigned to residents were available and working.

Interview with the ED on 02/02/23 at 4:58pm revealed:
-The MAs should not be sharing glucometers between residents.
-The facility's policy was that each resident had their own glucometer.
-There was no need to use another resident's glucometer.
-There was currently no system in place for routine audits of glucometers' history compared to FSBS values documented on residents' eMARs.

Interview with a medication aide (MA) on 02/02/23 at 5:10pm revealed:
-The facility had an approved cleaning and disinfecting solution available on the 100 Hall medication cart.
-She did not use the cleaning and disinfecting solution on the Brand A glucometer removed from the top drawer on the A Hall medication cart earlier today because she knew that was the resident's glucometer.
-She was not sure if she had used a glucometer to obtain FSBS value on a resident other than the one glucometer that was assigned to a resident.
-If she shared a glucometer she would have used the cleaning and disinfecting solution before and after use.

Interview with a second MA on 02/03/23 at 10:20am revealed:
-The facility policy was each resident had a glucometer assigned to the resident and staff were not supposed to share glucometers between residents.
-She did not recall having shared a glucometer in

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	HAL041010	A. BUILDING: _____ B. WING _____	R 02/03/2023

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D932	Continued From page 54 the past. Telephone interview with the facility's contracted PCP on 02/03/23 at 12:05pm revealed: -She had not been informed the facility was sharing glucometers between residents. -She would not expect the facility to be sharing a glucometer for more than one resident. -The risk for infection from blood born diseases was her concern for residents sharing glucometers. _____ The facility failed to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines for finger stick blood sugar checks which placed the residents at risk for possible exposure and transmission of blood borne pathogens by sharing of glucometers between Residents (#3, #7, and #8,). 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 02/02/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 19, 2023.	D932		