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ENO POINTE ASSISTED LIVING	5600 N ROXBORO ROAD DURHAM, NC 27712

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey with an exit date of November 2, 2023.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to implement physician orders for 1 of 5 sampled residents (#3) who had an order to recheck blood sugar within one hour after a blood sugar reading below 60 was obtained. The findings are: Review of Resident #3's current FL-2 dated 04/01/23 revealed a diagnosis of diabetes mellitus type 2. Review of Resident #3's signed physician orders dated 08/17/23 revealed: -There was an order for blood sugar checks three times daily with meals and at bedtime. -There was an order for Novolog 2 units with breakfast; hold if blood sugar reading was less than 60, give 4 ounces of orange juice, and recheck in 1 hour. -There was an order for Novolog 2 units with	D 276		

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lunch; hold if blood sugar reading was less than 60, give 4 ounces of orange juice, and recheck in 1 hour.
-There was an order for Novolog 4 units with supper; hold if blood sugar reading was less than 60, give 4 ounces of orange juice, and recheck in 1 hour.

Review of Resident #3's August 2023 electronic medication administration record (eMAR) revealed:
-There was an entry to hold Novolog for a blood sugar reading less than 60, give 4 ounces of orange juice, and recheck blood sugar in one hour.
-There was documentation that the blood sugar reading was 58 on 08/19/23 at 7:30am.
-There was documentation that the blood sugar reading was 54 on 08/24/23 at 5:30pm.
-There was no documentation the blood sugar was rechecked.

Review of Resident #3's September 2023 eMAR revealed:
-There was an entry to hold Novolog for a blood sugar reading less than 60, give 4 ounces of orange juice, and recheck blood sugar in one hour.
-There was documentation that the blood sugar reading was 52 on 09/05/23 at 7:30am.
-There was documentation that the blood sugar reading was 50 on 09/26/23 at 7:30am.
-There was documentation that the blood sugar reading was 42 on 09/27/23 at 5:30pm.
-There was no documentation that the blood sugar was rechecked.

Review of Resident #3's October 2023 eMAR revealed:
-There was an entry to hold Novolog for a blood

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sugar reading less than 60, give 4 ounces of orange juice, and recheck blood sugar in one hour.
-There was documentation that the blood sugar reading was 52 on 10/23/23 at 7:30am.
-There was no documentation that the blood sugar was rechecked.

Interview with Resident #3 on 11/03/23 at 9:09am revealed:
-He was a diabetic, had his blood sugar checked, and was administered insulin.
-He thought his blood sugar was checked three times a day.
-He did have low blood sugar readings and the facility staff would give him orange juice to bring his blood sugar up.
-He did not recall the facility staff re-checking his blood sugar 30 to 60 minutes after he was given orange juice.

Interview with a medication aide (MA) on 10/31/23 at 3:09pm revealed:
-She gave Resident #3 orange juice when his blood sugar was less than 60.
-She re-checked Resident #3's blood sugar 30 minutes to an hour after the orange juice was given.
-She documented the blood sugar reading for the re-check on the computer.
-She did not know there was no re-check of blood sugar in Resident #3's glucometer or documented in Resident #3's record.
-She thought she re-checked Resident #3's blood sugar and documented the readings in the computer.

Telephone interview with a second MA on 11/02/23 at 10:39am revealed:
-She gave Resident #3 orange juice when his

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blood sugar reading was below 60.
-She would re-check Resident #3's blood sugar 30 to 60 minutes after she gave Resident #3 orange juice.
-She would document in the Resident's record that she notified the PCP and what the re-check blood sugar reading was.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 11/01/23 at 2:44pm revealed:
-Resident #3 had an order to re-check his blood sugar within 60 minutes after giving him orange juice for a low blood sugar reading.
-The MAs should re-check Resident #3's blood sugar to ensure his blood sugar levels came up with the orange juice.
-Resident #3's blood sugar may not have increased above 60 with the orange juice.
-Resident #3 could still be hypoglycemic even with the orange juice.
-If the blood sugar readings did not increase, then further treatment would be needed.
-Resident #3 may need additional food or glucose to increase his blood sugar.

Interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:56am revealed:
-The MAs should follow the PCP order to recheck blood sugars after administering orange juice for a blood sugar less than 60.
-There was nowhere on the eMAR to document the re-check of the blood sugar.
-The MAs could document the recheck in the resident's record.
-She would inform the PCP of the low blood sugar readings.
-The MA should document somewhere the PCP was notified.
-She thought they were rechecking blood sugars

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D 276	Continued From page 4 for readings below 60. -The rechecked blood sugar should be seen in the glucometer. -The MAs should make sure Resident #3's blood sugar came up. Interview with the Administrator on 11/02/23 at 1:16pm revealed: -The MAs should document the blood sugar readings for re-checks in the notes section on the eMAR. -She thought there were 2 areas on the eMAR where the MAs could document the blood sugar readings. -The MAs were expected to re-check a low blood sugar with the hour as ordered.	D 276		
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 serve a therapeutic diet as ordered by the primary care provider (PCP) for 5 of 6 sampled residents (#1, #2, #4, #5, #11) who had an order for a pureed diet (#1); a mechanical soft diet with chopped meats (#2, #5, #11), and a mechanical soft (#4). The findings are: Review of the facility's regular menu for lunch dated 10/31/23 revealed:	D 310		

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-Broccoli and cheese soup, club sandwich, soft pretzel bites, and coconut cream pie.
-The alternate entree choice included beefy hashbrown casserole and carrots.

Review of the facility's diet extensions therapeutic diet menu for lunch dated 10/31/23 revealed:
-The mechanical soft diet for ground or chopped meats was broccoli and cheese soup, ground/chopped turkey sandwich, cheese puffs/cheese, and banana cream pie.
-The alternate entree choice included beefy hashbrown casserole and soft chopped carrots.
-The pureed diet was pureed broccoli and cheese soup, pureed pretzel bites, and pureed coconut cream pie.
-The alternate entree choice included pureed beefy hashbrown casserole and pureed carrots.

Review of the facility's regular menu for breakfast dated 11/01/23 revealed was a half of a banana, cereal, eggs, breakfast meat, and assorted muffins.

Review of the facility's menu and diet extensions therapeutic diet menu for breakfast dated 11/01/23 revealed pureed banana, hot cereal or pureed cold cereal, pureed egg, pureed breakfast meat, and pureed muffin.

Review of the facility's regular menu for lunch dated 11/01/23 revealed:
-Spaghetti and meatballs, a tossed salad, fruit with topping, and a bread stick.
-The alternate entrée choice was the chefs' choice.

Review of the facility's menu and diet extensions therapeutic diet menu for lunch dated 11/01/23 revealed:

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D 310	Continued From page 6 - The mechanical soft diet for ground or chopped meats was spaghetti and meatballs, soft, cooked vegetables, soft diced peaches with whipped topping, and bread with margarine. -The alternate entree choice included ground/chopped chef's choice meat with gravy and chopped chef's choice vegetable. -The pureed diet was pureed spaghetti and meatballs, pureed soft, cooked vegetables, pureed peaches with whipped topping, and a pureed bread stick. -The alternate entree choice was the chef's choice pureed. 1. Review of Resident #2's current FL-2 dated 10/03/23 revealed: -Diagnoses included cirrhosis of the liver, diabetes mellitus, and encephalopathy. -There was an order for consistent carbohydrates and mechanical soft with chopped meats. Review of Resident #2's tray card revealed a consistent-carbohydrate chopped diet. Observation of the lunch meal service on 10/31/23 at 12:12pm revealed: -Resident #2 was served beefy hashbrown casserole and carrots. -Resident #2 refused to eat the meal provided and asked for a sandwich. -Resident #2 was not served a sandwich and left the dining room without eating. Observation of the lunch meal service on 11/01/23 at 12:30pm revealed: -Resident #2 was served a turkey sandwich on white bread and a tossed salad with cheese. -Resident #2 was observed coughing as he spit a piece of lettuce from the salad back onto his plate.	D 310		

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-Resident #2 ate his sandwich; he did not eat his salad.

Interview with Resident #2 on 11/02/23 at 8:36am revealed:
-He did not know what his order was for meals, "they gave him whatever they wanted him to eat."
-He did not have teeth and could not eat certain foods.
-He could not eat his salad because he could not eat lettuce, but he forgot and he "choked it back up."
-He sometimes missed meals because he did not have the food he wanted.
-Sometimes they gave him something else to eat and sometimes they did not.
-He had gotten "choked plenty of times" when trying to eat food that he could not eat.

Telephone interview with Resident #2's Primary Care Provider (PCP) on 11/01/23 at 2:35pm revealed:
-Resident #2 did not have teeth.
-If Resident #2 asked for something different to eat, he should have been given something else to eat.
-Resident #2 needed to have protein regularly because of his diagnosis.
-"The more protein the better."
-If Resident #2 was not administered his diet as ordered it increased his risk of aspiration pneumonia and that was concerning because the resident wanted to be a do not resuscitate (DNR) and remain at the facility.

Interview with a medication aide (MA) on 11/02/23 at 10:18am revealed:
-She had seen Resident #2 not like what was provided, asked for something else and did not want that either, and then left the dining room.

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D 310	Continued From page 8 -She had not seen him have any problems with chewing his food or choking. Interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:21am revealed Resident #2 did not have teeth; she was not aware of any issues with eating. Refer to the interview with a personal care aide (PCA) on 11/02/23 at 8:47am. Refer to the interview with the Dietary Manager (DM) on 11/02/23 at 9:07am and 1:22pm. Refer to the interview with a MA on 11/02/23 at 10:18am. Refer to the interview with the RCC on 11/02/23 at 11:21am. Refer to the interview with the Administrator on 11/02/23 at 1:08pm. 2. Review of Resident #4's current FL-2 dated 11/03/22 revealed: -Diagnoses included Alzheimer's. skin cancer, and osteoarthritis. -There was an order for a mechanical soft diet. Review of Resident #4's tray card revealed a mechanical soft diet. Observation of the lunch meal service on 10/31/23 at 12:10pm revealed: -Resident #4 was served a bowl of broccoli and cheese soup, a sandwich with turkey, bacon, lettuce, and tomato on white bread; it was cut into two pieces. -She was also served pretzel bites cut in half and a bowl of pudding-based dessert.	D 310		

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-Resident #4 was observed coughing while eating a bite of her sandwich.
-Resident #4 ate 50% of her soup and 100% of her dessert.
-One half of the sandwich was torn apart and pieces of turkey, lettuce, and tomato were lying on the plate with a small piece of the bread; the remainder of the sandwich was on the plate untouched.
-Resident #4 did not eat her pretzel bites.

Observation of the lunch meal service on 11/01/23 at 12:20pm revealed:
-Resident #4 was served spaghetti with large meatballs, a tossed salad with lettuce, cheese, and tomatoes, a bread stick cut into four-inch pieces, and a pudding-based dessert.
-Resident #4 ate 100% of her dessert, four meatballs, none of the breadstick, the remainder of her meal did not appear to have been eaten.

Interview with Resident #4 on 11/01/23 at 8:45am revealed:
-She had a problem with chewing because she did not have teeth.
-She would try anything that was provided to her, but she may not be able to eat it.
-Some foods were too hard to eat.
-She did not need much to eat.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 11/01/23 at 2:35pm revealed:
-Resident #4 was ordered a mechanical soft diet because she did not have teeth.
-If Resident #4 was not administered her diet as ordered it increased her risk of aspiration pneumonia.

Interview with a medication aide (MA) on 11/02/23

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at 10:18am revealed she had not seen Resident #4 have any problems with choking; she did not eat much.

Interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:21am revealed Resident #4 did not have teeth; she was not aware of any issues with eating.

Refer to the interview with a personal care aide (PCA) on 11/02/23 at 8:47am.

Refer to the interview with the Dietary Manager (DM) on 11/02/23 at 9:07am and 1:22pm.

Refer to the interview with a MA on 11/02/23 at 10:18am.

Refer to the interview with the RCC on 11/02/23 at 11:21am.

Refer to the interview with the Administrator on 11/02/23 at 1:08pm.

3. Review of Resident #11's current FL-2 dated 04/04/23 revealed diagnoses included anemia and osteoporosis.

Review of Resident #11's signed physician order dated 10/26/23 revealed an order for a mechanical soft diet with chopped meats.

Review of Resident #11's tray card revealed a mechanical soft chopped meat diet.

Observation of the lunch meal service on 10/31/23 at 12:12pm revealed:
-Resident #11 was served a bowl of broccoli and cheddar cheese soup, a turkey sandwich with lettuce and tomato, pretzel bites, and a

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pudding-based dessert.
-Resident #11 ate 100% of her soup and dessert.
-Resident #11's plate contained piles of chewed lettuce, tomato, and turkey, and the edges of her bread.

Observation of the lunch meal service on 11/01/23 at 12:20pm revealed:
-Resident #11 was served spaghetti with large meatballs, a tossed salad with lettuce, cheese, and tomatoes, a bread stick cut into four-inch pieces, and a pudding-based dessert.
-Resident #11 ate ¼ of her spaghetti noodles and 100% of her dessert; she did not eat her meatballs, salad, or her breadstick.

Interview with Resident #11 on 11/02/23 at 9:58am revealed:
-She had a problem with her teeth that made chewing more difficult.
-She had been served meats that were difficult to eat.
-She "could not chew lettuce up at all."
-If she was served foods easier to eat, she may eat more.

Interview with a medication aide (MA) on 11/02/23 at 10:18am revealed:
-She had not seen Resident #11 have any issues with eating.
-If Resident #11 had any issues she would let staff know.
-She did not know Resident #11 should not have been served a salad.

Telephone interview with Resident #11's primary care provider (PCP) on 11/01/23 at 2:35pm revealed:
-It was concerning Resident #11 was not served her diet as ordered because the resident had a

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low weight anyway and struggled to swallow because she was not able to hold her neck upright.
-She was concerned Resident #11 could choke.
-Resident #11 needed to get food into her since she was already low-weight.
-Resident #11 not being served a mechanical soft diet as ordered increased her risk of aspiration.
-Resident #11 was already at an increased risk of aspiration because of her neck issues.

Interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:21am revealed:
-Resident #11 had issues with her bottom teeth and that was what caused problems with eating.
-Resident #11 had mentioned to the PCP problems with eating a couple of months ago and they discussed pureed foods; she did not want that.

Refer to the interview with a personal care aide (PCA) on 11/02/23 at 8:47am.

Refer to the interview with the Dietary Manager (DM) on 11/02/23 at 9:07am and 1:22pm.

Refer to the interview with a MA on 11/02/23 at 10:18am.

Refer to the interview with the RCC on 11/02/23 at 11:21am.

Refer to the interview with the Administrator on 11/02/23 at 1:08pm.

4. Review of Resident #5's current FL-2 dated 12/27/22 revealed:
-Diagnoses included diabetes mellitus type 2, hypertension, hyperlipidemia, schizophrenia, chronic kidney disease stage 3, dementia.

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D 310	Continued From page 13 -There was an order for consistent carbohydrates and mechanical soft, chopped. Review of Resident #5's tray card revealed a chopped diet with no pork or bread and dessert was fruit only. Observation of the lunch meal service on 11/01/23 at 12:58pm revealed: -Resident #5 was served 5 slices of turkey, 5 slices of cheese, a tossed salad and peaches in whipped cream. -The turkey was cut in half and the cheese slice were 2 x 2 inches. -Resident #5 ate 100% of her lunch. Interview with Resident #5 on 11/02/23 at 8:22am revealed: -She did not know what diet she was on. -She could not have too much sugar and could not eat pork. -She asked the staff to cut up her food. -She did not have any problems chewing or swallowing her food. -If she did not like something that was served, she left it on her plate. Interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:21am revealed Resident #5 did a lot of coughing during meals, spitting back out what she had ate; other residents complained. Refer to the interview with a personal care aide (PCA) on 11/02/23 at 8:47am. Refer to the interview with the Dietary Manager (DM) on 11/02/23 at 9:07am and 1:22pm. Refer to the interview with a medication aide (MA)	D 310		

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D 310	Continued From page 14 on 11/02/23 at 10:18am. Refer to the interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:21am. Refer to the interview with the Administrator on 11/02/23 at 1:08pm. _____ Interview with a personal care aide (PCA) on 11/02/23 at 8:47am revealed: -Residents on mechanical soft chopped diets got the same food as the other residents but it was chopped. -Some foods could be a choking hazard such as bacon so that would be substituted with chopped sausage. -She thought a salad would be fine for the residents on a mechanical soft chopped diet because the lettuce was chopped. Interview with a cook on 11/02/23 at 8:58am revealed: -Salad could be served to residents on a mechanical soft chopped diet as long as it was cut up well. -She did not know lettuce should not be served to residents on a mechanical soft chopped diet. -She could not read and did not see the salad should be substituted with the soft, cooked vegetables. -She depended on other dietary staff to tell her what was on the menu. -The spaghetti and meatballs should have been cut up and the bread should have been chopped, not cut up. Interview with the Dietary Manager (DM) on 11/02/23 at 9:07am and 1:22pm revealed: -If she was in the kitchen, she made sure food was substituted based on the menu.	D 310		

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-Whoever was the last staff person on the line made sure the food plated matched the residents' dietary card.
-She was the cook yesterday, 11/01/23, and missed chopping the meatballs for a mechanical soft chopped diet.
-She was taught everything should be bite-sized for a chopped diet.
-She did not substitute the pretzels because she did not have cheese puffs; she did cut the pretzels up to be easier to eat.
-She thought the salad was fine because it was chopped up.
-She missed seeing the salad should have been substituted with soft, cooked vegetables.
-She usually followed the menu for substitutions.

_____

5. Review of Resident #1's current FL-2 dated 3/02/23 revealed:
-Diagnoses included Alzheimer's disease and hypertension.
-There was an order for a pureed, no added salt diet.

Review of Resident #1's tray card revealed a pureed diet.

Observation of the breakfast meal service on 11/01/23 at 8:17am revealed:
-Resident #1 was seated upright in a geri-chair.
-Resident #1 was served yogurt, grits, and ground sausage.
-Resident #1 was fed by a personal care aide (PCA).
-Resident #1 consumed 100% of her breakfast.

Observation of the lunch meal service on 11/01/23 at 12:17pm revealed:
-Resident #1 was seated upright in a geri-chair.

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D 310	Continued From page 16 -Resident #1 was served applesauce, pureed peaches and whipped cream and ground spaghetti meat sauce. -Resident #1 was fed by a PCA. -Resident #1 was observed moving something around in her mouth. -The PCA wiped something from Resident #1's mouth with a napkin. -Resident #1 was observed coughing once during the meal. -Resident #1 consumed 100 percent of applesauce and pureed peaches, and 25% of spaghetti meat sauce. Interview with the same PCA on 11/02/23 at 8:25am revealed: -Resident #1 was on a pureed diet and had to be fed by the facility staff. -She did not notice Resident #1 having any difficulty swallowing or problems with coughing when she fed Resident #1. -When Resident #1 found a chunk or piece of food in her mouth that was not pureed, she would spit it out. -She noticed Resident #1 clearing her throat at times, but she had never choked while she was feeding Resident #1. Interview with a medication aide on 11/03/23 at 9:31am revealed: -Resident #1 was ordered a pureed diet. -Pureed food was the consistency of baby food. -She did not notice Resident #3 having problems eating her meals or coughing. -She saw the brown meat on Resident #1 plate yesterday, and it was not pureed. -She had never seen Resident #1 spit her food out. -She did not mention the texture of the food for Resident #1 to anyone.	D 310		

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-She trusted the kitchen staff to know what each resident was to be served.

Interview with a cook on 11/02/23 at 8:58am revealed:
-She used a blender to puree food.
-If the food was too thick, she added hot water and if it was too thin, she added a thickener.

Interview with the Dietary Manager (DM) on 11/02/23 at 9:07am revealed:
-The blender was used for pureed foods.
-Pureed food should be like a soup, like a tomato soup.
-She had blended the meatballs with tomato sauce and water.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 11/01/23 at 2:35pm revealed:
-Resident #1 was on a pureed diet.
-Resident #1 has been on a pureed diet, since before she became her PCP.
-She was concerned that Resident #1 may have difficulty if the food served was not pureed.
-Resident #1's meat should be pureed and not ground.

Interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:21am revealed:
Resident #1 was on a pureed diet.
-She had not heard of any concerns related to Resident #1's meals.
-Resident #1 would sometimes spit, but not just at meals.
-Resident #1 had spit food across the room.
-Pureed meats were supposed to be like baby food.

Interview with the Administrator on 11/02/23 at

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D 310	Continued From page 18 11:16am revealed: -Resident #1 should be served a pureed diet as ordered. -Expected Resident #1 to be served a pureed diet. Refer to the interview with a PCA on 11/02/23 at 8:47am. Refer to the interview with the DM on 11/02/23 at 9:07am and 1:22pm. Refer to the interview with a MA on 11/02/23 at 10:18am. Refer to the interview with the RCC on 11/02/23 at 11:21am. Refer to the interview with the Administrator on 11/02/23 at 1:08pm. _____ Interview with a personal care aide (PCA) on 11/02/23 at 8:47am revealed: -She had worked in the kitchen on the serving line. -The cook prepared pureed, mechanical soft, and regular food in different containers. -When working in the kitchen she used the residents' dietary card to know what food to plate. -When she served plated food to the residents, she depended on the kitchen staff to plate the food correctly. Interview with the Dietary Manager (DM) on 11/02/23 at 9:07am and 1:22pm revealed the cook was responsible for making sure food was the right consistency to be served. Interview with a medication aide (MA) on 11/02/23 at 10:18am revealed:	D 310		

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D 310	Continued From page 19 -She helped serve residents' meals. -Each resident's tray had a name card with their diet listed. -She did not pay attention to the plated food but relied on the dietary staff to know "who got what." Interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:21am revealed: -She was responsible for making sure the dietary staff received the correct diet order for each resident. -Any changes in a resident's diet were given to the dietary staff and shown directly to the DM so the residents' card could be updated to make sure the next meal was served correctly. -She did not look at the menu to see what was supposed to be served. -She expected the dietary staff to follow the menu. -She was concerned if the resident was not served the correct food it could increase the resident's risk of choking. Interview with the Administrator on 11/02/23 at 1:08pm revealed: -She expected the dietary staff to follow the diet order using the therapeutic menu as a guide. -She often assisted with meals and ensured the therapeutic menu had been followed.	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	D 358		

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which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents sampled (#3) for record review including errors with two medications to manage blood sugar.

The findings are:

Review of the facility's blood sugar guidelines revealed:
-If the blood sugar was less than 60, repeat the test.
-If the second reading was below 60, hold the insulin and call the physician.
-If the blood sugar was greater than 300, repeat the test.
-If the second reading was greater than 300, administer the insulin and call the physician.

Review of Resident #3's current FL-2 dated 04/01/23 revealed diagnosis of diabetes mellitus type 2.

a. Review of Resident #3's signed physician order dated 08/15/23 revealed:
-There was an order to increase Tresiba to 15 (a long-acting insulin used to improve blood sugar controls) units every morning.
-There was no order to hold Tresiba for blood sugar readings less than 60.

Review of Resident #3's August 2023 electronic medication administration record (eMAR) from

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08/15/23 to 08/31/23 revealed:
-There was an entry for Tresiba 15 units to be administered every morning with a scheduled administration time of 7:30am.
-There was documentation Tresiba 15 units was administered from 08/16/23 to 08/18/23 and 08/20/23 to 08/31/23.
-There was documentation in the exception notes that Tresiba 15 units was not administered on 08/17/23 due to low blood sugar; but was documented as administered on the eMAR.
-There was documentation Tresiba 15 units was not administered on 08/19/23; the exception was the blood sugar was low.
-The blood sugar readings at 11:30am, on the days Tresiba was documented as not given, were 432 on 08/17/23 and 462 on 08/19/23.

Review of Resident #3's September 2023 eMAR revealed:
-There was an entry for Tresiba 15 units to be administered every morning with a scheduled administration time of 7:30am.
-There was documentation Tresiba 15 units was administered from 09/01/23 to 09/04/23, 09/06/23 to 09/18/23, 09/20/23 to 09/22/23, 09/24/23 to 09/25/23, and 09/27/23 to 09/30/23.
-There was documentation on 09/05/23, 09/19/23, 09/23/23, and 09/26/23 of "N" (N-none).
-The blood sugar readings at 11:30am, on the days Tresiba was documented as not given were, 387 on 09/05/23, 280 on 09/19/23, 265 on 09/23/23, 401 on 09/26/23.

Review of Resident #3's October 2023 eMAR revealed:
-There was an entry for Tresiba 15 units to be administered every morning with a scheduled administration time of 7:30am.
-There was documentation Tresiba 15 units were

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administered from 10/1/23 to 10/05/23, 10/07/23 to 10/22/23, on 10/25/23, from 10/27/23 to 10/28/23 and on 10/31/23.
-There was documentation on 10/06/23, 10/23/23, 10/24/23, 10/26/23, 10/29/23, and 10/30/23 of "N."
-The blood sugar readings at 11:30am, on the days Tresiba was documented as not given, were 417 on 10/06/23, 364 on 10/23/23, 498 on 10/24/23, 532 on 10/26/23, 182 on 10/29/23 and 497 on 10/30/23.

Observation of Resident #3's medication on hand on 10/31/23 at 2:09pm revealed there was a 10ml bottle of Tresiba with ¼ of the medication remaining.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/02/23 at 8:48am revealed:
-Resident #3 had an order for Tresiba 15 units daily dated 08/15/23.
-The pharmacy dispensed a 10ml bottle of Tresiba on 08/10/23 and 10/31/23.
-One bottle of Tresiba would last 66 days if administered 15 units daily.
-Tresiba was used to pull the sugar out of the bloodstream and keep the blood sugar from increasing.

Interview with Resident #3 on 11/03/23 at 9:09am revealed:
-He was a diabetic, had his blood sugar checked, and was administered insulin.
-He was administered insulin three to four times a day for his blood sugar.

Interview with a medication aide (MA) on 10/31/23 at 3:09pm revealed:
-When Resident #3 did not need Tresiba, she

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would document "N" on the eMAR.
-"N" meant no medication was given.
-She did not administer Resident #3's Tresiba because the resident's blood sugar was low.
-A low blood sugar was less than 60.
-She thought Tresiba was not to be given if Resident #3's blood sugar was less than 60.

Telephone interview with a second MA on 11/02/23 at 10:39am revealed:
-Resident #3 had an order for Tresiba 15 units daily.
-She administered Tresiba 15 units to Resident #3 daily unless his blood sugar was below 60.
-She held Resident #3's Tresiba if his blood sugar reading was below 60.
-When she documented "N" on the eMAR, that meant she did not administer the medication.
-No one told her to hold the Tresiba; she thought the Tresiba would lower the resident's blood sugar even more than it already was.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 11/01/23 at 2:44pm revealed:
-Resident #3 had an order for Tresiba 15 units every morning.
-Tresiba should be administered no matter what Resident #3's blood sugar readings were.
-If Tresiba was not administered as ordered, Resident #3's blood sugar could increase.
-When she reviewed Resident #3's blood sugar readings, she would titrate his medication based on the blood sugar readings and thought Resident #3 was being administered Tresiba as ordered.
-She expected Tresiba to be administered as ordered.

Interview with the Resident Care Coordinator

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D 358	Continued From page 24 (RCC) on 11/02/23 at 11:56am revealed: -Resident #3 had an order for Tresiba 15 units daily. -The facility's protocol was to hold insulin when the blood sugar reading was below 60. -If the MAs administered Tresiba when Resident #3's blood sugar reading was below 60, Resident #3's blood sugar may bottom out. -She would not have administered the Tresiba to Resident #3 if his blood sugar reading was less than 60. -She would have followed the facility policy and not have administered Tresiba. -The MAs document "N" on the eMAR when they held the medication. Interview with the Administrator on 11/02/23 at 1:16pm revealed she expected the MA to administer Resident #3's Tresiba as ordered unless the blood sugar was below 60. b. Review of Resident #3's current FL-2 dated 04/01/23 revealed: -There was an order for Novolog insulin (a short acting insulin used to manage blood sugar) 2 units with breakfast. -There was an order for Novolog insulin 3 units with lunch and dinner. -There was an order for Novolog sliding scale insulin (SSI) three times daily as follows: blood sugar reading between 200 - 300 give 1 unit, 301 - 400 give 2 units, 401- 500 give 3 units, and greater than 500 give 4 units and call the physician. Review of Resident #3's signed physician order dated 08/17/23 revealed: -There was an order for Novolog insulin 2 units at lunch. -There was an order for Novolog insulin 4 units at	D 358		

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D 358	Continued From page 25 dinner. Review of Resident #3's signed physician order dated 10/24/23 revealed: -There was an order to increase Novolog insulin to 4 units with breakfast. -There was an order to increase Novolog insulin to 5 units with lunch. -There was an order to continue Novolog insulin at 4 units with dinner. Review of Resident #3's August 2023 electronic medication administration record (eMAR) from 08/17/23 to 08/31/23 revealed: -There was an entry for Novolog 2 units with breakfast with a scheduled administration time of 7:30am; hold for blood sugar less than 60, give 4 ounces of orange juice, and recheck in one hour. -There was an "N" documented for a blood sugar reading of 67 on 08/17/23. -There was an entry for Novolog 4 units with dinner with a scheduled administration time of 5:30pm; hold for blood sugar less than 60, give 4 ounces of orange juice, and recheck in one hour. -There was an "N" documented for a blood sugar reading of 138 on 08/30/23. Review of Resident #3's September 2023 eMAR revealed: -There was an entry for Novolog 2 units with breakfast with a scheduled administration time of 7:30am; hold for blood sugar less than 60, give 4 ounces of orange juice, and recheck in one hour. -There was an "N" documented for blood sugar readings of 117 on 09/21/23, 481 on 09/22/23; and 127 on 09/23/23. -There was an entry for Novolog 2 units with lunch with a scheduled administration time of 11:30am; hold for blood sugar less than 60, give 4 ounces of orange juice, and recheck in one	D 358		

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ENO POINTE ASSISTED LIVING	5600 N ROXBORO ROAD DURHAM, NC 27712

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hour.
-There was an "N" documented for blood sugar readings of 62 on 09/01/22; 91 on 09/21/23; 562 on 09/22/23; and 265 on 09/23/23.
-There was an entry for Novolog 4 units with dinner with a scheduled administration time of 5:30pm; hold for blood sugar less than 60, give 4 ounces of orange juice, and recheck in one hour.
-There was an "N" documented for blood sugar readings of 144 on 09/05/23 and 399 on 09/11/23.

Review of Resident #3's October eMAR revealed:
-There was an entry for Novolog 2 units with breakfast with a scheduled administration time of 7:30am; hold for blood sugar less than 60, give 4 ounces of orange juice, and recheck in one hour.
-There was an "N" documented for blood sugar readings of 96 on 10/06/23 183 on 10/22/23; and 64 on 10/24/23.
-There was an entry for Novolog 4 units with breakfast with a scheduled administration time of 7:30am; hold for blood sugar less than 60, give 4 ounces of orange juice, and recheck in one hour.
-There was an "N" documented for blood sugar readings of 78 on 10/26/23 and 61 on 10/30/23.
-There was an entry for Novolog 2 units with lunch with a scheduled administration time of 11:30am; hold for blood sugar readings less than 60, give 4 ounces of orange juice, and recheck in one hour.
-There was an "N" documented for blood sugar readings of 65 on 10/20/23.
-There was an entry for Novolog 5 units with lunch with a scheduled administration time of 11:30am; hold for a blood sugar reading less than 60, give 4 ounces of juice, and recheck in one hour.
-There was an "N" documented for a blood sugar reading of 182 on 10/29/23.

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Interview with Resident #3 on 11/03/23 at 9:09am revealed:
-He was a diabetic, had his blood sugar checked, and was administered insulin.
-He thought his blood sugar was checked three times a day.

Interview with a medication aide (MA) on 10/31/23 at 3:09pm revealed:
-When Resident #3 did not need Novolog, she would document "N" on the eMAR.
-"N" meant no medication was given.
-The number of units of insulin to be administered would "pop" up on the eMAR when the blood sugar was entered.
-If no units popped up on the eMAR she did not administer Novolog insulin.
-She did not know why she documented "N" for blood sugar readings greater than 60.
-She should have administered Novolog insulin for blood sugar readings greater than 60.

Interview with a second MA on 10/31/23 at 3:31pm revealed:
-She did not administer Novolog insulin to Resident #3 if his blood sugar reading was less than 80.
-The facility policy stated to hold insulin if the blood sugar reading was less than 80.
-She followed the facility policy and not the PCP's order.
-She did not know if the facility policy overruled the PCP's order.

A second interview with the second MA on 10/31/13 at 3:45pm revealed:
-The facility policy stated to hold insulin if the blood sugar was less than 60, not 80 as previously stated.
-She should have administered the insulin for

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D 358	Continued From page 28 blood sugar readings greater than 60. Interview with a third MA on 10/31/23 at 3:39pm revealed: -When she documented "N" it meant that she did not administer Novolog insulin to Resident #3. -Resident #3 was on sliding scale insulin (SSI) and he did not get Novolog insulin if his blood sugar was less than 200. -She should have administered Novolog insulin for blood sugar readings greater than 60. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/02/23 at 8:48am revealed: -The most recent order for Novolog insulin for Resident #3 was 4 units at breakfast, 5 units at lunch, and 4 units at dinner, hold for blood sugar readings less than 60 and recheck in one hour. -Resident #3 had an order for Novolog 2 units for breakfast until the order increased to 4 units on 10/24/23. -Resident #3 had an order for Novolog 4 units at breakfast on 08/15/23 and it was increased to 5 units on 10/24/23. -Resident #3 had an order to increase Novolog insulin to 4 units on 10/24/23 for dinner. -There was an order for Novolog sliding scale insulin (SSI) three times daily as follows: blood sugar reading between 200 - 300 give 1 unit, 301 - 400 give 2 units, 401- 500 give 3 units, and greater than 500 give 4 units and call the Primary Care Provider (PCP). Telephone interview with Resident #3's PCP on 11/01/23 at 2:44pm revealed: -When she reviewed Resident #3's blood sugar readings, she would titrate his medication based on the blood sugar readings and thought Resident #3 was being administered his	D 358		

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D 358	Continued From page 29 medication as ordered. -She expected Novolog to be administered as ordered. Interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:56am revealed: -The MAs document "N" on the eMAR when they hold the medication. -The MAs should have administered Novolog when Resident #3's blood sugar was greater than 60. Interview with the Administrator on 11/02/23 at 1:16pm revealed she expected the MA to administer Novolog as ordered unless the blood sugar was 60. _____ The facility failed to ensure medications were administered as ordered for a resident who did not receive Tresiba and Novolog as ordered, and the resident continued to have elevated blood sugar readings (#3) which 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 11/01/23. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 17, 2023.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:	D 367		

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D 367	Continued From page 30 (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#3) including inaccurate documentation of blood sugar readings. The findings are: Review of Resident #3's current FL-2 dated 04/01/23 revealed diagnosis of diabetes mellitus type 2. Review of Resident #3's signed physician orders dated 08/17/23 revealed there was an order for blood sugar checks three times daily with meals and at bedtime. Review of Resident #3's October 2023 electronic medication administration record (eMAR) blood	D 367		

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sugar readings and glucometer history revealed:
-There was an entry for blood glucose checks three times daily at meals and at bedtime with a scheduled time of 7:30am, 11:30am, 4:30pm, and 9:00pm.
-On 10/03/23, there was a documented blood sugar reading of 294 at 9:00pm; the reading in Resident #3's glucometer history was 139 at 7:23pm.
-On 10/06/23, there was a documented blood sugar reading of 273 at 9:00pm; the reading in Resident #3's glucometer history was 373 at 7:16pm.
-On 10/07/23, there was a documented blood sugar reading of 276 at 9:00pm; the reading in Resident #3's glucometer history was 272 8:05pm.
-On 10/08/23, there was a documented blood sugar reading of 500 at 7:30am; the reading in Resident #3's glucometer history was 534 at 7:49am.
-On 10/08/23, there was a documented blood sugar reading of 597 at 11:30am; the reading in Resident #3's glucometer history was 581 at 11:38am.
-On 10/12/23, there was a documented blood sugar reading of 149 at 9:00pm; the reading in Resident #3's glucometer history was 137 at 7:42pm.
-On 10/14/23, there was a documented blood sugar reading of 249 at 9:00pm; the reading in Resident #3's glucometer history was 240 at 9:39pm.
-On 10/24/23, there was a documented blood sugar reading of 64 at 7:30am; the reading in Resident #3's glucometer history was 54 at 7:46am.
-On 10/24/23, there was a documented blood sugar reading of 498 at 11:30am; the reading in Resident #3's glucometer history was 548 at

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D 367	Continued From page 32 11:27am. -On 10/27/23, there was a documented blood sugar reading of 223 at 9:00pm; the reading in Resident #3's glucometer history was 288 at 7:23pm. -On 10/28/23, there was a documented blood sugar reading of 126 at 5:30pm; the reading in Resident #3's glucometer history was 128 at 5:16pm. -On 10/30/23, there was a documented blood sugar reading of 497 at 11:30am; the reading in Resident #3's glucometer history was 543 11:44am. Interview with a medication aide on 11/02/23 at 9:57am revealed: -She did not know why the documentation on the eMAR was different from the reading on the glucometer. -She must have hit the wrong number on the keyboard. Telephone interview with a medication aide on 11/02/23 at 10:39am revealed: -She did not know why the documentation of the eMAR was different than the reading in the glucometer. -She documented the reading in the glucometer into the eMAR. Telephone interview with Resident #3's Primary Care Provider (PCP) on 11/01/23 at 2:44pm revealed: -She expected to have accurate blood sugar readings when she reviewed Resident #3's record. -It was concerning to her that some of the blood sugar readings were documented incorrectly. -She could not make an accurate medical decision to adjust medication accordingly if she	D 367		

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D 367	Continued From page 33 did not have the correct information. Interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:56am revealed: -The blood sugars readings on the eMAR should match the blood sugar readings in Resident #3's glucometer. -The MAs must be documenting the incorrect number in the eMAR. -The MAs should document the blood sugar reading as soon as it was obtained. -The MAs need to slow down and make sure the blood sugar reading entry is correct before saving the information in the eMAR. Interview with the Administrator on 11/02/23 at 1:16pm revealed: -The blood sugar reading on the eMAR and the glucometer should be the same. -The MAs were expected to document the correct blood sugar reading on the eMAR.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	D 375		

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This Rule is not met as evidenced by:
Based on observations, record review, and interviews, the facility failed to ensure 1 of 3 sampled residents (#1) had a physician's order to self-administer a medication used to treat arthritic pain.

The findings are:

Review of the facility's Medication Administration policy revealed:
-Self-administering of medications required a physician's order.
-Residents who self-administered medications required pre-approval by the Administrator and the Resident Care Coordinator (RCC).
-Families were not allowed to bring medications to the resident directly but must deliver to medications to a Medication Aide (MA) or the RCC.

Review of Resident #6's current FL-2 dated 09/01/23 revealed:
-Diagnoses included major neurocognitive disorder, mild dementia, severe protein calorie malnutrition, cannabis abuse, chronic venous stasis, and chronic obstructive pulmonary disease.
-There was no order for Tylenol Arthritis
-There was no order for self-administration.

Observation of Resident #6's room on 10/31/23 at approximately 9:30am revealed:
-There was a half-full bottle of Tylenol Arthritis 650 milligrams (mg) on top of the resident's dresser visible from the room entrance.
-The bottle had no pharmacy label for instructions

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D 375	Continued From page 35 for use or self-administration. Observation of Resident #6's room on 10/31/23 at 2:50pm revealed: -There was a half-full bottle of Tylenol Arthritis 650 milligrams (mg) on top of the resident's dresser visible from the room entrance. -The bottle of Tylenol Arthritis had not been removed from Resident #6's room by staff. Review of Resident #6's record revealed: -There was no physician's order for Resident #6 for the use of Tylenol Arthritis. -There was no physician's order for self-administration of medications. -There was no assessment for self-administration of medications. Review of the August 2023, September 2023, and October 2023 electronic medication administration record (eMARs) for Resident #6 revealed: -There was no order for Tylenol arthritis 650 mg. -There was no self-administer order for Tylenol arthritis. Interview with Resident #6 on 10/31/23 at 2:50pm revealed: -Another resident gave him a bottle of Tylenol Arthritis. -He had rheumatoid arthritis (RA). -He had flare-ups of his RA but not every day. -He took the medication when the pain was bad. -He took the medication at lunchtime but did not take it every day. -He kept the bottle of medication on his dresser. -The staff had never said anything about the bottle of medication being in his room. -He had not completed an assessment to self-administer his medications.	D 375		

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D 375	Continued From page 36 Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/01/23 at 11:51am revealed: -Tylenol Arthritis was used to treat aches and pains. -Resident #6 did not have an order for Tylenol Arthritis. -Resident #6 did not have an order to self-administer medications. -It was not recommended that Tylenol Arthritis be left at the bedside due to the risk of overdose. -Medications should not be left out in the open in resident rooms. -There was a risk of other residents accidentally taking the medication if left out in the open. Telephone interview with Resident #7's Primary Care Provider (PCP) on 11/01/23 at 3:13pm revealed: -Resident #6 had cognitive impairment. -Resident #6 should not be able to self-administer his medications. -Concern for over usage of Tylenol Arthritis could be a multi-organ failure. -She expected staff to be alert to medications left at the bedside and remove them or alert the RCC. Interview with a personal care aide (PCA) on 11/02/23 at 4:30pm revealed: -She was unaware Resident #6 had a bottle of Tylenol Arthritis in his room. -She knew residents were not supposed to have medications out in the open. -She would let the MA or the RCC know if she found medications at the bedside. Interview with a MA on 11/01/23 at 10:50am revealed:	D 375		

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-Resident #6 did not have an order for Tylenol Arthritis.
-Resident #6 did not have an order to self-administer medications.
-She was unaware Resident #6 had Tylenol Arthritis on his dresser; she did not see it.
-She would remove medications left at the bedside if the resident did not have an order and let the RCC or Administrator know.

Interview with the RCC on 11/02/23 at 11:21am revealed:
-Resident #6 did not have an order to self-administer his medications.
-She was unaware Resident #6 had Tylenol Arthritis at the bedside.
-If a family member brought medications in from outside of the facility, they were to check them in with her.
-She had not been given any medications for Resident #6.
-Resident #6 knew he was unable to keep medications at the bedside.
-She expected MAs and PCAs to look around resident rooms and bring medications to her if found.

Interview with the Administrator on 11/02/23 at 1:08pm revealed:
-Residents who self-administered medications should have orders to self-administer.
-Residents should have orders for all medications.
-If staff saw medications at the bedside, they should be removed.
-Resident rooms should be monitored for medications brought from outside the facility.
-If a family member brought medication in, it was to be brought to the RCC.
-She expected the Medication Administration

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D 375	Continued From page 38 policy to be followed.	D 375		
D 611	10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following: (1) Standard and transmission-based precautions, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of	D 611		

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D 611	Continued From page 39 illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak. 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, #9, and #10) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. The findings are: Review of the Center for Disease Control and Prevention (CDC) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents.	D 611		

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Review of the manufacturer's manual for Brand A glucometers revealed:
-Indirect transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV) during the delivery of healthcare services have been increasingly reported by persons using glucose monitoring systems as a risk group due to sharing of blood glucose meters.
-The FDA Public Health notification: Use of a finger-stick device on more than one person posed a risk for transmitting blood-borne pathogens.
-CDC Clinical Reminder: Use of a finger-stick device on more than one person posed a risk for transmitting blood-borne pathogens.

Review of the facility's diabetic testing policy dated 06/06/19 revealed:
-Individual glucometers were provided for each resident.
-Do not share glucometers; do not use on multiple residents.

Observation of the facility's medication room on 11/01/23 11:02am revealed there were multiple black zippered cases labeled with residents' names in a cabinet in the medication room.

1. Review of Resident #3's current FL-2 dated 04/01/23 revealed:
-There was a diagnosis of diabetes mellitus type 2.
-There was an order for blood sugar checks with meals and at bedtime.

Observation of Resident #3's Brand A glucometer on 11/01/23 at 11:09am revealed:
-The glucometer was in a black zippered bag

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labeled with Resident #3's name.
-The glucometer was not labeled with Resident #3's name.
-The current date on the glucometer was 11/01/23 at 10:52am.

Review of Resident #3's October 2023 electronic medication administration record (eMAR) blood sugar readings and glucometer history revealed:
-There was an entry for blood sugar checks three times a day and with meals with a scheduled time of 7:30am, 11:30am, 4:30pm and 9:00pm.
-On 10/02/23, there was a documented reading of 125 at 9:00pm; the blood sugar reading was not recorded in Resident #3's glucometer history.
-On 10/04/23, there was a documented reading of 166 at 9:00pm; the blood sugar reading was not recorded in Resident #3's glucometer history.
-On 10/05/23, there was a documented reading of 154 at 9:00pm; the blood sugar reading was recorded in Resident #3's glucometer history.
-On 10/05/23, there was an additional blood sugar reading of 281 at 8:06pm on Resident #3's glucometer history that was not documented on Resident #3's eMAR.
-On 10/09/23, there was a documented reading of 321 at 5:30pm; the blood sugar was recorded in Resident #3's glucometer history.
-On 10/09/23, there was an additional blood sugar reading of 167 at 5:08pm on Resident #3's glucometer history that was not documented on Resident #3's eMAR.
-The blood sugar reading of 167 at 5:08pm in Resident #3's glucometer history was documented on Resident #10's eMAR.
-On 10/14/23, there was a documented reading of 497 at 11:30am; the blood sugar reading was not recorded in Resident 3's glucometer history.
-On 10/14/23, there was a documented reading of 249 at 9:00pm; the blood sugar was not recorded

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in Resident #3's glucometer history.
-On 10/14/23, there were two blood sugar readings of 252 at 8:44pm and 240 at 9:39pm on Resident #3's glucometer history; the blood sugar readings were not documented on Resident #3's eMAR.
-On 10/14/23, there was a documented reading of 94 at 5:30pm; the blood sugar reading was not recorded in Resident #3's glucometer history.
-On 10/14/23, there were two blood sugar readings of 247 at 4:44pm and 186 at 5:07pm on Resident #3's glucometer history; the blood sugar readings were not documented on Resident #3's eMAR.
-On 10/20/23, there was a documented reading of 111 at 9:00pm; the blood sugar reading was not recorded in Resident #3's glucometer history.
-On 10/22/23, there was a documented reading of 183 at 7:30am; the blood sugar reading was not recorded in Resident #3's glucometer history.
-On 10/22/23, there were three blood sugar readings of 185 at 7:29am, 145 at 7:36am, and 196 at 7:42am in Resident #3's glucometer history; the blood sugar readings were not recorded in Resident #3's glucometer history.
-The blood sugar reading of 196 at 7:42am in Resident #3's glucometer history was documented on Resident #10's eMAR.
-On 10/23/23, there was a documented blood sugar reading of 364 at 11:30; the blood sugar reading was on Resident #3's glucometer history.
-On 10/23/23, there was another blood sugar reading of 313 at 11:31am on Resident #3's glucometer readings; the blood sugar was not documented on Resident #3's eMAR.
-On 10/24/23, there was a documented reading of 64 at 7:30am and 498 at 11:30am; the blood sugar readings were not in Resident #3's glucometer history.
-On 10/24/23, there were two blood sugar

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readings of 54 at 7:46am and 548 at 11:27am; the readings were not on Resident #3's eMAR.
-On 10/26/23, there was a documented reading of 420 at 5:30pm and a 266 at 9:00pm; the blood sugar readings were not in Resident #3's glucometer history.
-On 10/27/23, there was a documented reading of 395 at 11:55am; the blood sugar reading was in Resident #3's glucometer history.
-On 10/27/23, there were two additional blood sugar readings of 114 at 11:03am and 306 at 11:04am in Resident #3's glucometer history; the readings were not documented in Resident #3's eMAR.

Interview with Resident #3 on 11/03/23 at 9:09am revealed:
-He was a diabetic and had his blood sugar checked three to four times daily.
-He would go to the medication room to check his blood sugar most of the time.
-Sometimes the MA would check his blood sugar in his room.
-He did not know whose glucometer the MA used to check his blood sugar.

Interview with a medication aide (MA) on 11/03/23 at 9:57am revealed:
-She did not know why there were three readings in Resident #3's glucometer on the same day within one hour.
-There was no reason to re-check Resident #3's blood sugar since it was not below 60.

Refer to the interview with a MA on 11/03/23 at 9:57am.

Refer to the telephone interview with a second MA on 11/02/23 at 10:39am.

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D 611	Continued From page 44 Refer to the telephone interview with the Primary Care Provider (PCP) on 11/01/23 at 3:16pm. Refer to the interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:56am. Refer to the interview with the Administrator on 11/02/23 at 11:16pm. 2. Review of Resident #10's current FL-2 dated 10/03/23 revealed: -Diagnoses included diabetes mellitus. -There was an order for fingerstick blood sugar (FSBS) checks twice daily before breakfast and dinner. Observation of Resident #10's Brand A glucometer on 11/01/23 at 10:47am revealed: -The glucometer was in a black zippered bag labeled with Resident #10's name. -The glucometer was not labeled with Resident #10's name. -The current date on the glucometer was 11/01/23 and the time was 10:47am. Review of Resident #10's October 2023 electronic medication administration record (eMAR) FSBS readings and glucometer history revealed: -There was an entry for FSBS checks twice daily before breakfast and dinner with a scheduled administration time of 7:30am and 5:30pm. -On 10/09/23 there was a documented reading of 167 at 5:30pm; this FSBS reading was not recorded in Resident #10's glucometer's history. -On 10/14/23 there was a documented reading of 147 at 5:30pm; this FSBS reading was not recorded in Resident #10's glucometer's history. -On 10/20/23 there was a documented reading of 167 at 7:30am and 155 at 5:30pm; these	D 611		

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readings were recorded in Resident #10's glucometer history.
-On 10/20/23 there were two additional readings in Resident #10's glucometer history, 111 at 8:26pm and 208 at 9:09pm; these readings were not documented on Resident #10's eMAR.
-The blood sugar reading of 111 at 8:26pm in Resident #10's glucometer history was documented on Resident #3's eMAR.
-On 10/21/23 there was a documented reading of 129 at 5:30pm; this FSBS reading was not recorded in Resident #10's glucometer's history.
-On 10/22/23 there was a documented reading of 196 at 7:30am; this FSBS reading was not recorded in Resident #10's glucometer's history.
-On 10/26/23 there was a documented reading of 144 at 5:30pm; this FSBS reading was not recorded in Resident #10's glucometer's history.
-On 10/27/23 there was a documented reading of 193 at 7:30am and 174 at 5:30pm; these FSBS readings were recorded in Resident #10's glucometer's history.
-On 10/27/23 there were two additional readings in Resident #10's glucometer history, 118 at 10:56am and 317 at 10:56am; these readings were not documented on Resident #10's eMAR.

Interview with Resident #10 on 11/02/23 at 10:26am revealed:
-Staff checked his blood sugar twice a day.
-He always had his blood sugar checked in the medication room.
-His glucometer was in a pouch with his name on it.
-He did not look at the pouch every time to make sure his pouch was used.

Refer to the interview with a medication aide (MA) on 11/03/23 at 9:57am.

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D 611	Continued From page 46 Refer to the telephone interview with a second MA on 11/02/23 at 10:39am. Refer to the telephone interview with the Primary Care Provider (PCP) on 11/01/23 at 3:16pm. Refer to the interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:56am. Refer to the interview with the Administrator on 11/02/23 at 11:16pm. 3. Review of Resident #9's current FL-2 dated 02/09/23 revealed: -Diagnoses included diabetes mellitus type 2. -There was an order for fingerstick blood sugar (FSBS) checks three times a day and at bedtime. Observation of Resident #9's Brand A glucometer on 11/01/23 at 11:32am revealed: -The glucometer was in a black zippered bag labeled with Resident #9's name. -The glucometer was not labeled with Resident #9's name. -The current date on the glucometer was 11/01/23 and the time was 11:48am. Review of Resident #9's October 2023 electronic medication administration record (eMAR) FSBS readings and glucometer history revealed: -There was an entry for FSBS checks three times a day and at bedtime with scheduled administration times of 7:30am, 11:30am, 5:30pm and 8:00pm. -On 10/02/23 there was a documented reading of 180 at 5:30pm; this FSBS reading was not recorded in Resident #9's glucometer history. -On 10/02/23 there was a documented reading of 176 at 8:00pm; this FSBS reading was not recorded in Resident #'9's glucometer history.	D 611		

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D 611	Continued From page 47 -On 10/04/23 there was a documented reading of 244 at 8:00pm; this FSBS reading was not recorded in Resident #9's glucometer history. -On 10/05/23 there was a documented reading of 236 at 8:00pm; this FSBS reading was not recorded in Resident #9's glucometer history. -On 10/14/23 there was a documented reading of 247 at 5:30pm; this FSBS reading was not recorded in Resident #9's glucometer history. -On 10/14/23 there was a documented reading of 214 at 8:00pm; this FSBS reading was not recorded in Resident #9's glucometer history. -On 10/20/23 there was a documented reading of 123 at 8:00 pm; this FSBS reading was not recorded in Resident #9's glucometer history. -On 10/21/23 there was a documented reading of 229 at 8:00pm, this FSBS reading was not recorded in Resident #9's glucometer history. -On 10/22/23 there was an additional reading of 342 at 11:40am; this FSBS was documented on Resident #3's eMAR. -On 10/26/23 there was a documented reading of 169 at 8:00pm, this FSBS reading was not recorded in Resident #9's glucometer history. -On 10/26/23 there was an additional reading of 420 at 5:30pm; this reading was not documented on Resident #9/s eMAR. -On 10/26/23 there was an additional reading of 266 at 9:10pm; this reading was documented on Resident #3's eMAR. -On 10/27/23 there were two additional readings in Resident #9's glucometer history, 113 at 11:14am and 308 at 11;15am; these readings were not documented on Resident #9's eMAR. Interview with Resident #9 on 11/02/23 at 9:00am revealed: -He got his blood sugar checked twice a day by the staff. -He did not have a glucometer in his room, the	D 611		

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D 611	Continued From page 48 staff used their glucometer. -Staff did not miss checking his blood sugar. Refer to the interview with a medication aide (MA) on 11/03/23 at 9:57am. Refer to the telephone interview with a second MA on 11/02/23 at 10:39am. Refer to the telephone interview with the Primary Care Provider (PCP) on 11/01/23 at 3:16pm. Refer to the interview with the Resident Care Coordinator (RCC) on 11/02/23 at 11:56am. Refer to the interview with the Administrator on 11/02/23 at 11:16pm. _____ Interview with a MA on 11/03/23 at 9:57am revealed: -Each resident who had an order for blood sugar checks, had their own glucometer. -She did not share glucometers among the residents. -There was no reason why a resident's glucometer had to be used on another resident. -New glucometers were kept in the facility and available if needed. -She did not know where the blood glucose entry on the eMAR came from since the blood glucose reading was not in the glucometer. -Some of the MAs could have mixed up the glucometers since there were no names on the glucometers. -Glucometers should not be shared because of blood-borne pathogens and infection control. Telephone interview with a second MA on 11/02/23 at 10:39am revealed: -Each resident who had blood glucose checks	D 611		

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had a glucometer.
-There was no reason to share glucometers among the residents.
-She would retrieve a new meter if a resident's meter broke or the battery gave out and she did not have a battery to replace.

Telephone interview with the PCP on 11/01/23 at 3:16pm revealed:
-Each resident should have their own glucometer.
-There was an increased risk of infection related to blood-borne pathogens when glucometers were shared.

Interview with the RCC on 11/02/23 at 11:56am revealed:
-The only situation where a blood sugar reading in a glucometer should be close together would be a re-check and it should be at least 15 minutes apart.
-Each resident with diabetes had their own glucometer.
-They did not share glucometers because there was a chance to spread infection.
-There was no reason for glucometers to be shared; new glucometers were always kept in the facility.
-Each glucometer should have the resident's name written on it and should be kept in the case with the resident's name on it.
-She had written the resident's name on the glucometer, but the name would come off when the glucometer was cleaned.
-She did not know why there were multiple readings on the glucometers and not documented on the eMARs, why some readings were on the glucometers and documented on a different resident eMAR
-The MAs may have mixed up the glucometers since the names were no longer on the meters.

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D 611	Continued From page 50 Interview with the Administrator on 11/02/23 at 11:16pm revealed: -The facility had single-use glucometers. -Glucometers were not to be shared because of infection control issues. -The MAs should not multi-use any glucometer among residents. _____ The facility failed to implement infection control procedures consistent with the Centers for Disease Control and Prevention (CDC) guidelines resulted in staff sharing glucometers for 3 of 3 sampled diabetic residents, placing residents at risk for bloodborne pathogen diseases. This failure was detrimental to the health, safety, and welfare of the residents, and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/01/23 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 17, 2023.	D 611		