Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060171	A. BUILDING: _____ B. WING _____	R 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF CHARLOTTE	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and follow up survey and a complaint investigation on 10/23/24 through 10/25/24.	D 000		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physician ordered therapeutic diets were served for 1 of 2 sampled residents (#5) related to nectar thickened liquids. The findings are: Review of Resident #5's current FL2 dated 09/22/24 revealed diagnoses included vascular dementia, hypertension, anticoagulation therapy, cardiac pacemaker, and insomnia. Review of Resident #5's Care Plan dated 09/11/24 revealed the resident required assistance with meals. Review of Resident #5's hospitalist physician's order dated 10/07/24 revealed a pureed diet with nectar, mildly thick liquids. CS	D 310	1. All diet orders reviewed and clarified to make sure they are correct in the ALIS system. 2. Updated information shared with DSD to make sure culinary board is accurate. 3. Education to be completed by 12/9/2024 regarding diet orders and following diet order process. 4. Diet order roster/ board will be readily available for Med Tech/ SIC and will be monitored for meals. ED, HWD, or designee will review the diet orders upon admission. Any changes will be reviewed by the nurse and communicated with the DSD. The ED, HWD, or designee will review and added or changed diet order to ALIS. DSD will review and changes with the culinary team and check/ update communication board to be utilized by staff. ED, HWD, or designee will audit. Audits will be completed weekly x4 weeks and then monthly going forward. Date of comploiance 12/ 9/ 2024	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jenn L Robin — Executive Director — 12-6-24

Reviewed and Acknowledged
Date: 12/11/24 CS

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D 310	Continued From page 1 Review of Resident #5's registered dietitian order dated 10/04/24 revealed a puree diet, nectar/mildly thick liquids, meal supervision with one on one assistance to prevent aspiration. Review of the lunch meal menu for 10/23/24 revealed salad, crispy fried chicken, potato wedges, corn bread, and cherry cobbler. Observation of the diet roster report on 10/23/24 at 10:15am posted on a bulletin board in the kitchen revealed Resident #5 was to be served a regular diet, pureed consistency, nectar thickened liquids with one to one feeding assistance. Observation of the lunch meal and beverage service on 10/23/24 at 12:00pm revealed: - Resident #5 was served a meal tray in her room with mashed potatoes, pureed green beans, yogurt, pureed chicken with gravy along with a nutritional supplement drink and water that was not nectar/mild think. -Resident #5 received one on one meal assistance from a medication aide. -Resident #5 ate 50% of her meal and drank 10% of the nutritional supplement and was given water that was not nectar /mildly thickened by staff. -Resident #5 was observed to start coughing after she swallowed the water. Observation of the lunch meal at 12:43pm revealed: -Staff was observed giving water to Resident #5. - Resident #5 was observed coughing after being given water by staff. -The medication aide was immediately asked if the water was thickened. Interview with a medication aide (MA) on 10/23/24 at 12:43pm revealed:	D 310		

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D 310	Continued From page 2 -The water was not thickened with any nectar. -She gave water to Resident #5 because Resident #5 liked water and asked for it often. -The water was brought in by a family member. -She was aware the resident was on nectar thickened liquids, but she thought it was ok to serve water that was not thickened to Resident #5. Interview with Resident #5's Power of Attorney (POA) revealed: -She was aware Resident #5 was on a nectar thickened liquid diet. -She brought bottled waters in for Resident #5 because Resident #5 requested them. -She was aware the water needed to be thickened. -She left the bottled waters in Resident #5's room. Interview with the Dietary Manager (DM) on 10/25/24 at 10:27am revealed: -He kept a board in the kitchen that had each resident's diet on it and included cards on the individual tray with diet orders. -He expected staff to check the board and cards on the trays prior to giving residents meals or go to the MA or a nurse to find out diet orders. -He had a supply of nectar thickened beverages on hand, including water. -He knew Resident #5 was only to be served nectar thickened liquids. -He was not sure why staff gave the resident thin liquids that were not nectar thick. Interview with a personal care aide (PCA) on 10/24/24 at 2:11pm revealed: -She was aware Resident #5 was on nectar thickened liquids. -She had given her water without it being	D 310		

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D 310	Continued From page 3 thickened on 10/23/24 at dinner time. -She had not been told by anyone that Resident #5 could not have water that was not nectar thickened. -She was told about diet orders from the MAs. Telephone interviews with Resident #5's Hospice Nurse on 10/24/24 at 4:29pm and 10/25/24 at 11:23am and 2:41pm revealed: -She knew Resident #5 was ordered pureed diet with nectar thickened liquids when the resident was at the hospital. -She was not sure why the hospital put the resident on nectar thickened liquids. -If Resident #5 required nectar thickened liquids, she could aspirate if given liquids that were not thickened. -On 10/25/24 she reassessed Resident #5 and it was determined that she would need to remain on nectar thickened liquids due to coughing observed while consuming plain liquids. Interview with the Resident Care Coordinator (RCC) on 10/25/24 at 11:55am revealed: -Diet orders were sent out to the DM and the DM made foods accordingly. -She was not sure what diet Resident #5 was ordered after returning from hospital in October 2024, but knew she was on mechanical soft with thin liquids prior to going to hospital. -She had always reported diet orders to the Health and Wellness Director (HWD), who was on leave at the current time. Interview with the Administrator on 10/25/24 at 12:21pm revealed: -When new diets orders were received, the HWD was responsible for letting the DM know about diets. -She was not sure why staff did not know that	D 310		

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D 310	Continued From page 4 they should not give regular liquids to Resident #5 on a nectar thickened liquid diet. _____ The facility failed to ensure nectar thickened liquids were served as ordered to Resident #5 resulting in a coughing episode during the lunch meal service. The failure increased the risk of aspiration and was detrimental to the health, safety and welfare of Resident #5 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 23, 2024 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 09, 2024.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record	D 344	1. ED, HWD, or designee conducted a review of all new admission orders upon admission for accuracy. 2. HWD or designee will review all new admission documentation for verification and clarification from PCP as needed. 3. HWD, ED, or designee will audit and monitor current resident orders quarterly for accuracy. Completion date 12/30/2024	

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D 344	Continued From page 5 reviews the facility failed to clarify orders for 3 of 7 sampled residents (#6, #11, #12) related to oxygen (#6) and finger stick blood sugars (#11, #12). The findings are: Review of Resident #6's current FL2 dated 09/25/24 revealed: -Diagnoses included congestive heart failure, obstructive sleep apnea and hypertension. -There was no order for oxygen therapy. Review of Resident #6's Care Plan dated 10/04/24 revealed, in the "assistive/adaptive devices" section that documented "oxygen" but there was no other information included. Review of Resident #6's Resident Register revealed no date of admission. Review of Resident #6's Pre-Admission Assessment forms revealed no documentation of her need for oxygen therapy. Interview with a medication aide (MA) on 10/23/24 at 10:20am revealed: -She usually worked in the Special Care Unit (SCU) as a MA, but yesterday she worked in Assisted Living (AL) as a personal care aide (PCA) and Resident #6 was one of the residents assigned to her. -Resident #6 had an oxygen concentrator upon admission to the facility a few weeks ago. -She did not know how many liters of oxygen Resident #6 required or if she required continuous or as needed oxygen. Review of Resident #6's progress notes revealed: -She was admitted to the facility at 11:00am and	D 344		

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D 344	Continued From page 6 was on 2 liters of continuous oxygen "at this time" via concentrator. -The Health and Wellness Director (HWD) entered "added oxygen assistance 2 liters on concentrator for as needed" on 10/04/24 at 1:18pm. Review of Resident #6's October 2024 electronic Medication Administration Record (eMAR) revealed no documentation of oxygen therapy administration. Observation of Resident #6 on 10/23/24 at 9:47pm revealed: -Resident #6 was in bed with her bed in the raised position. -Resident #6's oxygen concentrator was sitting approximately 20 inches from the bed, and there was a nasal cannula attached to the concentrator that was draped over the concentrator. -Resident #6's oxygen saturation reading, taken by the MA via pulse oximetry on 10/23/24 at 9:50am was 94% (normal results >95-100%). Interview with Resident #6 on 10/23/24 at 9:50am revealed: -She moved into the facility a few weeks ago. -She wore her oxygen nasal cannula "mostly all the time" but sometimes took it off and forgot about it. -She could not reach the concentrator, where the cannula was located, from her bed. -She was unsure how long she had used oxygen but recalled she had it "a long time" before she moved to the facility. -She did not know how much oxygen she was supposed to be using, or if she was supposed to wear at all times. Interview with a PCA on 10/24/24 at 9:30am	D 344		

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D 344	Continued From page 7 revealed: -Resident #6 moved to the facility from her home a few months ago. -Since moving into the facility, Resident #6 always had the oxygen concentrator by her bed and usually wore her nasal cannula. -Upon admission, the HWD directed staff to ensure Resident #6 kept her nasal cannula on "all the time". -Resident #6 sometimes took off her nasal cannula and forgot to put it back on. -She was not assigned to Resident #6 yesterday (10/23/24) but was in her room at the time Resident #6 was observed to not be wearing oxygen. -She did not know how much oxygen Resident #6 required or if she was supposed to wear it continuously or as needed. Interview with a MA on 10/24/24 at 9:55am revealed: -She did not know if anyone had followed up with Resident #6's physician regarding her need for oxygen therapy. -She was unsure if there was an order for Resident #6's oxygen therapy. -She recalled seeing Resident #6 yesterday at 7:00am and she was wearing the nasal cannula at that time. Telephone interview with Resident #6's physician's office representative on 10/25/24 at 9:05am revealed: -The facility contacted the office yesterday (10/24/24), and inquired about Resident #6's oxygen order. -No one from the facility had contacted the office before yesterday to inquire about the oxygen order. -Resident #6's oxygen order was for 2 liters,	D 344		

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D 344	Continued From page 8 continuous, via nasal cannula. Telephone interview with the facility Licensed Health Professional Support (LHPS) Registered Nurse (RN) on 10/25/24 at 8:55am revealed: -She usually visited the facility at least twice monthly and completed LHPS reviews for residents. -She did not recall having any questions about Resident #6's oxygen order. Interview with the Admissions Coordinator on 10/25/24 at 12:45pm revealed: -Resident #6's family brought her to the facility, with most of her belongings, including her oxygen, when she was admitted to the facility. -She did not recall any discussion with Resident #6, her family, or the HWD, regarding her need for oxygen therapy. Interview with the Resident Care Coordinator (RCC) on 10/25/24 at 2:12pm revealed: -The HWD was responsible for reviewing new resident's orders and documentation upon admission. -Since Resident #6 had lived in the facility, she had observed her to "always" wear a nasal cannula. -She was unaware Resident #6 did not have an order for oxygen therapy and she never reached out to the provider to get an order. -The HWD was responsible for obtaining clarification orders and should have known an order was needed when Resident #6 was admitted to the facility. Interview with the Regional Director of Operations (RDO) on 10/25/24 at 2:30pm revealed: -She conducted the initial assessment of Resident #6 prior to her admission to the facility.	D 344		

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D 344	Continued From page 9 -During the visit, she observed Resident #6 wearing an oxygen nasal cannula. -She visited Resident #6 again prior to admission and recalled she was not wearing her nasal cannula during the visit. -She did not recall discussing Resident #6's oxygen therapy during the visit. -The HWD was responsible for and should have reached out to Resident #6's physician upon admission to the facility to inquire about her oxygen needs since it was not included on the FL2. -She was unsure how the need for an oxygen order was missed by the admission coordinator and HWD. Interview with the Administrator 10/25/24 at 9:23am revealed: -The HWD was responsible for ensuring all orders were in place when a resident was admitted to the facility, and that all orders were reviewed for accuracy once a resident was admitted. -The HWD worked with the Admissions Coordinator prior to admission to ensure admissions went smoothly, and that all necessary orders had been obtained. -She did not recall any conversations about Resident #6's oxygen prior to or after admission. -She was unsure why no staff identified that there was no order for Resident #6's oxygen. 2. Review of Resident #11's current FL2 dated 06/13/24 revealed: -Diagnoses included type 2 diabetes mellitus, essential primary hypertension, and chronic kidney disease. -There was an order for Mounjaro (used to lower blood sugar) 5mg/0.5ml inject 0.5mg every week on Friday.	D 344		

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D 344	Continued From page 10 Review of Resident #11's skilled nursing facility discharge summary dated 06/13/24 revealed there was an order for fingerstick blood sugar (FSBS) check two times a day and as needed; call medical doctor if FSBS less than 60 or greater than 400. Review of Resident #11's primary care provider (PCP) orders dated 08/28/24 revealed: -There was an order for glargine-yfgn 100u/ml inject 12 units daily at bedtime. -There was an order for Mounjaro 5mg/0.5ml inject 0.5ml every week on Friday. Review of Resident #11's PCP order dated 09/30/24 revealed: -Discontinue insulin glargine-yfgn. -Lantus (a long-acting insulin used to lower blood sugar) 100u/ml inject 12 units daily at bedtime. Review of Resident #11's September 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Autoshield mis 30gx5mm (this is a brand name safety pen needle that attaches to an insulin pen) scheduled daily at 8:00pm. -FSBS values were documented on 09/09/24, 09/12/24, 09/13/24, 09/14/24, 09/15/24, 09/20/24, and 09/26/24. -There was an entry for glargine-yfgn 100u/ml scheduled daily at 8:00pm. -The glargine-yfgn with FSBS values were documented on 09/08/24, 09/14/24, and 09/28/24. -The FSBS range was 153-216 from 09/01/24-09/30/24. Review of Resident #11's October 2024 eMAR	D 344		

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D 344	Continued From page 11 revealed: -There was an entry for Autoshield mis 30gx5mm scheduled daily at 8:00pm. -FSBS values were documented on 10/02/24, 10/05/24, 10/07/24, 10/12/24, 10/17/24, and 10/18/24. -There was an entry for Lantus inject 12 units daily at bedtime scheduled at 8:00pm. -There were administration notes for the Lantus with FSBS values were documented on 10/03/24, 10/08/24, 10/09/24, 10/10/24, 10/11/24, 10/12/24, 10/13/24, 10/20/24, and 10/21/24. -There was an entry for FSBS scheduled at 8:00pm with values documented on 10/04/24, 10/06/24, 10/13/24, 10/14/24, and 10/24/24. -The FSBS range was 131-197 from 10/01/24-10/24/24. Interview with a medication aide (MA) on 10/24/24 at 3:50pm revealed: -There were residents who were ordered long acting insulin, but did not have an entry on the eMAR to check a FSBS prior to administering the long acting insulin. -She did not want to administer insulin without knowing what the resident's FSBS was prior to administering insulin. -She would obtain a FSBS prior to administering insulin and document the FSBS result in the administration notes of the insulin entry in the eMAR. -She checked the FSBS because she did not want a resident's blood sugar to "bottom out." Interview with the Resident Care Coordinator (RCC) on 10/25/24 at 9:45am revealed the Health and Wellness Director (HWD) was responsible for reviewing and clarifying PCP orders. Interview with Resident #11 on 10/25/24 at	D 344		

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D 344	Continued From page 12 10:15am revealed she received FSBS checks once a day before bed. Telephone interview with Resident #11's PCP on 10/25/24 at 11:36am revealed: -The facility did not contact her to clarify the FSBS order not being on the 06/13/24 FL2. -Resident #11 was on long acting insulin and the facility "probably" needed an order for once a day FSBS checks. Interview with the Administrator on 10/25/24 at 12:17pm revealed the HWD was responsible for reviewing admission orders and clarifying any questions about the orders with the PCP. 3. Review of Resident #12's current FL2 dated 04/29/24 revealed: -Diagnoses included dementia, controlled hypertension, and diabetes mellitus type 2. -There was an order for insulin glargine (a long-acting insulin used to lower blood sugar) 25 units daily at bedtime. Review of Resident #12's PCP order dated 06/01/24 revealed Lantus (a long-acting insulin used to lower blood sugar) 100u/ml inject 25 units every night at bedtime. Review of Resident #12's after visit summary updated medication list dated 06/04/24 revealed: -Insulin glargine-yfgn 100u/ml inject 25 units daily at bedtime. -Brand B glucose test strip use one strip for testing fingerstick blood sugar (FSBS) twice a day. -The Brand B glucose test strip order had three refills remaining, an expiration date of 12/21/24, and last fill date of 12/21/23.	D 344		

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D 344	Continued From page 13 Review of Resident #12's hospital discharge summary dated 07/17/24 revealed insulin glargine 100u/ml 25 units daily at bedtime. Review of Resident #12's PCP order dated 09/20/24 revealed Lantus 30 unit every night at bedtime. Review of Resident #12's September 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Lantus inject 30 units every night at bedtime scheduled for 8:00pm. -There were FSBS values documented in the administration notes on 09/21/24 and 09/30/24. -There was a discontinued entry on 09/20/24 for Lantus inject 25 unit every night at bedtime. -There was FSBS value of high (means the blood glucose level is very high exceeding the maximum range the device used to test can measure) documented in the Lantus administration notes on 09/18/24 and on 09/30/24. -There was a FSBS of 414 documented on 09/21/24. Review of Resident #12's October 2024 eMAR revealed: -There was an entry for Lantus 100u/ml inject 30 units every night at bedtime scheduled for 8:00pm. -There were FSBS values documented in the administration notes on 10/12/24 and 10/15/24. Interview with the Resident Care Coordinator (RCC) on 10/24/24 at 10:30am revealed Resident #12 did not have a current order for FSBS testing. Interview with a medication aide (MA) on 10/24/24 at 3:50pm revealed:	D 344		

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D 344	Continued From page 14 -There were residents who were ordered long acting insulin, but did not have an entry on the eMAR to check a FSBS prior to administering the long acting insulin. -She did not want to administer insulin without knowing what the FSBS was prior to administering insulin. -She would check a FSBS prior to administering insulin and document the FSBS result in the administration notes of the insulin entry in the eMAR. -She checked the FSBS because she did not want a resident's blood sugar to "bottom out." Interview with the RCC on 10/25/24 at 9:45am revealed the Health and Wellness Director (HWD) was responsible for reviewing and clarifying PCP orders. Interview with the Administrator on 10/25/24 at 12:17pm revealed the HWD was responsible for reviewing all orders and clarifying any questions about the orders with the PCP. Attempted telephone interview with Resident #12's PCP on 10/25/24 at 11:59am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #12 was not interviewable.	D 344		
D 349	10A NCAC 13F .1002 (f) Medication Orders 10A NCAC 13F .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration are	D 349	1. ED, HWD, or designee conducted a review of all new admission orders upon admission for accuracy. Verification and Clarification of orders are obtained by PCP as needed. 2. HWD or designee will review all new admission documentation for verification and clarification from PCP as needed. 3. HWD, ED, or designee will audit and monitor current resident orders quarterly for accuracy. Date of complaince 12/30/2024	

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D 349	Continued From page 15 reviewed and signed by the resident's physician or prescribing practitioner at least every six months. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure all current orders for medications and treatments were reviewed and signed by the residents primary care provider (PCP) at least every six months for 2 of 5 sampled residents (#2 and #3). The findings are: 1. Review of Resident #2's current FL2 dated 11/01/23 revealed diagnoses including diabetes mellitus, chronic kidney disease stage 4, hypertension, sleep apnea, and chronic diastolic congestive heart failure. Review of Resident #2's record revealed there was a medication review dated 02/21/24 signed by the primary care provider (PCP). Review of Resident #2's record revealed there was no medication review after the one completed on 02/21/24. Refer to interview with the Resident Care Coordinator on 10/25/24 at 9:45am. Refer to interview with the Regional Director of Operations on 10/25/24 at 10:30am. Refer to interview with the Administrator on 10/25/24 at 12:17pm. 2. Review of Resident #3's current FL2 dated	D 349		

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D 349	Continued From page 16 11/08/23 revealed diagnoses included multiple sclerosis, anxiety disorder, gastro-esophageal reflux disease and hypotension. Review of Resident #3's record revealed there was a medication review dated 02/28/24 signed by the primary care provider (PCP). Review of Resident #3's record revealed there was no medication review after the one completed on 02/28/24. Refer to interview with the Resident Care Coordinator on 10/25/24 at 9:45am. Refer to interview with the Regional Director of Operations on 10/25/24 at 10:30am. Refer to interview with the Administrator on 10/25/24 at 12:17pm. Interview with the Resident Care Coordinator on 10/25/24 at 9:45am revealed: -The Health and Wellness Director (HWD) was not available for interview. -The HWD was responsible for obtaining six month medication and treatment reviews for the residents. -She did not know how the HWD knew when six month medication and treatment reviews were due to be completed. -The facility's primary care provider (PCP) made visits to the facility twice a week and would have been available to sign any six month medication and treatment reviews. Interview with the Regional Director of Operations on 10/25/24 at 10:30am revealed she thought staff at the facility's contract pharmacy was responsible for obtaining six month medication	D 349		

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D 349	Continued From page 17 and treatment reviews for all of the residents from their PCPs. Interview with the Administrator on 10/25/24 at 12:17pm revealed the HWD was responsible for obtaining six month medication and treatment reviews for all of the residents from their PCPs.	D 349		
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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure medications were stored securely as evidenced by two medication carts that were left unlocked and unattended. The findings are: Review of the facility's policy on medication administration dated 10/2021 revealed: -Medications for residents who receive assistance with administration of medication must be stored in an appropriately locked storage area accessible to authorized staff only. -Medication carts must be locked and secured when not in immediate use. -All medication carts must be under visual control	D 378	1. The two Med Techs that were found to have unlocked carts were immediately counseled on the importance of locked carts when unattended per regulation. 2. Reminder education was provided to all Med Techs on the importance of locked carts when unattended per regulation through [redacted] 3. Random safety check audits by management team throughout the day for the next 30 days and as needed thereafter. 4. All new employees will be trained in Medication Cart Safety. Date of Completion 12/09/2024	

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D 378	Continued From page 18 of the responsible staff member when not in use. Review of the facility census dated 10/23/24 revealed: -Fifteen residents lived on the second floor. -Twenty residents lived on the third floor. Observations outside resident room 206 on 10/23/24 at 11:40am revealed: -The 200 hall medication cart was pushed against the wall to the right of room 206. -The medication cart was unlocked and unsupervised by the medication aide (MA) responsible for the cart. -The MA was inside room 206 with the door open as she assisted the resident inside. Interview with the MA on 10/23/24 at 11:43am revealed she had left the medication cart unlocked for a brief time to respond to the resident in room 206 who needed her assistance. Observation of the same MA on 10/23/24 at 11:51am revealed: -The MA exited room 213. -The MA attempted to access supplies located inside the locked medication cart. -The MA was unable to find the keys to unlock the medication cart. -The MA walked back to room 206. -The medication cart keys were lying on the top of a chest of drawers inside room 206. Telephone interview with the Senior Director of Wellness on 10/24/24 at 4:15pm revealed: -The MA who had left the 200 hall medication cart unlocked and unattended had left the medication cart quickly to respond to calls for help from the resident in room 206. -The MAs all were trained to never leave the	D 378		

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D 378	Continued From page 19 medication carts unlocked and unattended. Interview with the Administrator on 10/25/24 at 9:10am revealed: -The MA who left the 200 hall medication cart unlocked and unattended had been "distracted" and "forgot" to press the button to lock the cart. -The MAs were trained to "slow down" and lock the carts. -The MAs knew the medication carts had to be locked when unattended. Observation on the third floor on 10/23/24 at 3:59pm revealed: -The medication cart was unlocked and unattended. -No medication aides (MA) were in sight on the floor until 4:00pm when a MA came from around the corner and started walking toward the medication cart. -A resident exited the elevator and walked past the medication cart to go to her room. Interview with a MA on 10/23/24 at 4:00pm revealed: -She was the MA assigned to the third floor. -She normally locked the medication cart when she left it unattended. -She forgot to lock it when she walked away from it a moment ago but she was just down the hall. Interview with the Regional Director of Operations on 10/25/24 at 8:00am revealed: -All MAs were trained to lock the medication cart whenever they left it unattended. -She thought the MA were distracted when they left the cart unattended on 10/23/24. The facility failed to ensure the medication carts on the second and third floor remained locked	D 378		

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D 378	Continued From page 20 whenever they were left unattended, leaving it available for residents to obtain wrong medications which was detrimental to the safety of the 35 residents that lived on the two floors and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 23, 2024 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 09, 2024.	D 378		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the local county Department of Social Services (DSS) was notified when 2 of 3 sampled residents (#3, and #5) who had incidents/accidents that required emergency medical treatment. 1. Review of Resident #5's current FL2 dated	D 451	1. HWD, ED, or designee will verify all qualifying incidents are submitted to DHHS per regulatory requirements. 2. Staff will notify ED, HWD, or designee of any indidents. ED, HWD, or designee will report to DHHS per regulatory requirements. 3. ED, HWD, or designee will conduct weekly audits at stand-up to verify all incidents were reported per regulatory requirements. Date of completion 12/30/2024	

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D 451	Continued From page 21 09/22/24 revealed: -Diagnoses included vascular dementia, hypertension, anticoagulation therapy, cardiac pacemaker, and insomnia. -The level of care was documented as Special Care Unit (SCU). Review of the Resident Register dated 10/23/20 for Resident #5 revealed: -There was an admission date of 10/23/20. -There was a Power of Attorney (POA) appointed. Review of an Accident/Incident Report for Resident #5 dated 05/26/24 revealed: -On 05/26/24 Resident #5 was walking from her room to the dining room and tripped over a scale in the hallway. -Resident #5 complained of pain. -Resident was transferred to the Hospital by Emergency Management Services (EMS) on 05/26/24. -The family, physician, and Executive Director (ED) were notified. -There was no documentation that the local county DSS had been notified. Review of an Accident/Incident Report for Resident #5 dated 06/01/24 revealed: -On 06/01/24, Resident #5 was found unresponsive when staff were going to put her down for bed. -Resident #5's body was limp and clammy. -She did not respond to her name being called or sternum rubbed. -Staff were unable to get blood pressure, pulse, or oxygen stat on Resident #5. -She was breathing, but had long pauses in between each breath. -EMS was unable to get blood pressure on Resident #5.	D 451		

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D 451	Continued From page 22 -Resident #5 was transferred to the Hospital by EMS on 06/01/24. -Resident #5's family, health and wellness director (HWD), and physician were notified. -There was no documentation that the local county DSS had been notified. Review of an Accident/Incident Report for Resident #5 dated 06/26/24 revealed: -Resident #5 had a witnessed fall in the hallway. -She lost balance and fell. -She hit her head and split her stitches to right outer thigh. -Right outer thigh was red and bleeding. -Resident #5 complained of pain. -She was transferred to hospital by EMS on 06/26/24. -Resident #5's family, HWD, and physician were notified. -There was no documentation that the local county DSS had been notified. Refer to interview with the Adult Home Specialist (AHS) on 10/24/24 at 11:30am and 10/25/24 at 9:23am. Refer to interview with the Resident Care Coordinator (RCC) on 10/25/24 at 11:55am. Refer to interview with the Administrator on 10/25/24 at 8:00am and 12:21pm. 2. Review of Resident #3's current FL2 dated 11/08/23 revealed diagnoses included multiple sclerosis. Review of Resident #3's Resident Register dated 01/13/23 revealed an admission date of 01/19/23. Review of Resident #3's Accident /Incident Report	D 451		

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D 451	Continued From page 23 dated 10/18/24 revealed: -There was documentation of an unwitnessed fall at 10:29pm. -There was documentation Resident #3 was bleeding from her forehead. -There was documentation Resident #3 was transported to a local hospital. -There was no documentation DSS was notified of the accident/Incident. Refer to interview with the Adult Home Specialist (AHS) on 10/24/24 at 11:30am and 10/25/24 at 9:23am. Refer to interview with the RCC on 10/25/24 at 11:55am. Refer to interview with the Administrator on 10/25/24 at 8:00am and 12:21pm. Interview with a Mecklenburg County Adult Home Specialist (AHS) on 10/24/24 at 11:30am and 10/25/24 at 9:23am revealed she had not been notified of accidents that required emergency treatment at the local hospital on 05/26/24, 06/01/24, 06/26/24 and 10/18/24. Interview with the RCC on 10/25/24 at 11:55am revealed: -The residents' physician and POA were notified of the accidents that required the residents to be treated at the hospital. -The medication aides (MAs) were supposed to complete the Accident/Incident Reports, notify the POAs and the resident's physician. -The Administrator would notify DSS within 48 hours of when the incidents were sent out. -She was not sure why accident/ incidents requiring transportation to the local hospital were not reported to DSS.	D 451		

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D 451	Continued From page 24 Interview with the Administrator on 10/25/24 at 8:00am and 12:21pm revealed: -The MAs completed the Accident/Incident Reports. -The MAs were expected to informed her when incident/accidents occurred. -The previous Executive Director (ED) would have been responsible for making sure the incidents were reported to DSS prior to August 2024 and the HWD was responsible for reporting to DSS since August 2024. -She was not sure why accident/ incidents requiring transportation to the local hospital were not reported to DSS.	D 451		
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	D 611	1. Glucometer unit in question was immediately discarded. 2. All Med Carts were reviewed/ audited to verify a all glucometers were labeled resident specific. 3. Notification to Med Techs completed regarding NO GLUCOMETER sharing via [redacted] to all staff. 4. Staff were in-serviced on 11/7/2024 and 11/20/2024 by [redacted] from the office of Communicable Disease of Mecklenburg County. 5. Weekly Med Cart Audits to be completed by RCC or designee for three months. Completion date 12/09/2024	

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D 611	Continued From page 25 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 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 (CDC) and Prevention guidelines to ensure proper infection control procedures for the use of glucometers for 5 of 5 sampled residents (#2, #11, #12, #13, and	D 611		

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D 611	Continued From page 26 #14) with diabetes and orders fingerstick blood sugar (FSBS) checks, resulting in sharing of a glucometer between residents. The findings are: Review of the CDC guidelines for infection control revealed: -The CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. -If you must share a glucometer in a healthcare or congregate setting, select a device designed for use in professional settings, not an over-the-counter device. -Clean and disinfect blood glucose meters after every use, per the manufacturer's instructions. Review of the facility's infection control program policy dated 04/17/24 revealed the program addressing the surveillance, prevention and control of infections will include training for staff including blood glucose monitoring practices consistent with the CDC recommendations. 1. Review of #13's current FL2 dated 04/11/24 revealed diagnoses included dementia, history of glucose intolerance, osteoarthritis, edema from old injury and congestive heart failure, pacemaker for cardiac arrhythmia, hypertension, and gastroesophageal disease. Review of the facility's current census for 10/23/24 revealed Resident #13's room was located on the 200 hall. Observation of the medication aide (MA) for 200 hall on 10/23/24 at 11:44am revealed: -The MA donned a pair of gloves. -The MA opened the top drawer of the medication	D 611		

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D 611	Continued From page 27 cart. -The MA took out a single use lancet and alcohol swab from the top drawer of the medication cart. -The MA took out an unlabeled black zipper pouch which contained an unlabeled glucometer and a bottle of reagent strips. -The glucometer and bottle of reagent strips inside the zippered pouch were not labeled with a resident name. Review of the manufacturer's user manual for the glucometer revealed the glucose monitoring system was intended to be used by a single person and should not be shared. Interview with the MA on 10/23/24 at 11:47am revealed: -Resident #13 needed a FSBS check. -The resident routinely wore a continuous glucose monitor (CGM are wearable devices that measure and track blood sugar levels in real time). -The resident's family had not yet delivered a new CGM sensor, so they were required to perform FSBS checks to monitor the resident's blood sugar until the new CGM sensor was delivered. -The resident had their own glucometer in their room, however this morning when she had tried to use the resident's glucometer the battery was dead. -This morning she used the unlabeled glucometer stored on the medication cart to obtain the FSBS check for the resident. -She did not know the glucometer was for single use only and should not be shared between residents. Interview with Resident #13's companion on 10/23/24 at 11:48am revealed a staff member had replaced the battery in Resident #13's	D 611		

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D 611	Continued From page 28 glucometer that morning. Observation on 10/23/24 at 11:49am revealed: -The same MA donned a new pair of gloves. -She obtained Resident #13's glucometer from a table in the room and powered on the glucometer. -The MA used proper infection prevention techniques to obtain a FSBS from Resident #13. -The MA disposed of the single use lancing device and the test strip in a biohazard waste container and the gloves and used alcohol swab in the trash. -She did not clean Resident #13's glucometer after use. Interview with the MA on 10/23/24 at 11:55am revealed: -The multi-use unlabeled glucometer stored on the cart was a glucometer that had not been assigned to a resident. -She had never used the unlabeled glucometer to check a FSBS before this morning. -She did not know how long the unlabeled glucometer had been stored in the top drawer of the medication cart. -She had wiped the unlabeled glucometer down with an alcohol wipe this morning prior to using it. -All the other residents with orders for FSBS checks had their own glucometers. Review of Resident #13's primary care provider (PCP) order dated 05/01/24 revealed: -Okay to use blood glucose levels from continuous glucose monitor (CGM). -Blood glucose checks four times a day. Review of Resident #13's PCP order dated 05/07/24 revealed: -A CGM kit to check and monitor blood sugar four times a day.	D 611		

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D 611	Continued From page 29 -Change CGM sensor every 10 days. Review of Resident #13's PCP order dated 06/01/24 revealed: -Check blood glucose four times a day via CGM sensor. -Change CGM sensor every 14 days. Review of Resident #13's PCP order dated 06/05/24 revealed: -Hold CGM 06/03/24-06/07/24. -Discontinue CGM. Review of Resident #13's PCP order dated 06/12/24 revealed please reduce fingerstick's/glucose monitoring to twice a day effective today. Review of Resident #13's PCP order with no date on the order revealed may use fingerstick to check/monitor blood glucose. Review of Resident #13's vital signs details report dated 10/18/24-10/23/24 revealed FSBS values were documented on the vital sign details report four times a day. Review of the unlabeled glucometer FSBS values recorded in the history from 10/18/24-10/23/24 revealed: -The date was 10/23/24 at 12:51pm when the glucometer was powered on 10/23/24 at 12:47pm. -There were 6 FSBS values recorded in the history of the glucometer dated 10/18/24-10/22/24. -There were 3 FSBS values recorded in the history matched the FSBS values documented on Resident #13's vital sign details report dated 10/18/24-10/23/24.	D 611		

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D 611	Continued From page 30 -On 10/18/24 at 8:13am the FSBS was 113 and the documented FSBS on Resident #13's vital sign details report on 10/18/24 at 8:12am was 113. -On 10/18/24 at 11:48am the FSBS was 136 and the documented FSBS on Resident #13's vital sign details report on 10/18/24 at 11:47am was 136. -On 10/22/24 at 8:06pm the FSBS was 78 and the documented FSBS on Resident #13's vital sign details report on 10/22/24 at 8:00pm was 78. Telephone interview with Resident #13's family member on 10/23/24 at 3:14pm revealed: -Resident #13 had recently been hospitalized and returned to the facilty on 10/17/24. -The hospital had removed Resident #13's CGM sensor. -The family member had been trying to find a source to purchase another CGM sensor for Resident #13 since her return to the facility on 10/17/24. -The facility was required to obtain FSBS checks until another CGM sensor could be applied. Interview with a second MA on 10/23/24 at 4:00pm revealed: -Resident #13 required FSBS checks. -Resident #13 had her own glucometer that was stored on the table inside her room. Refer to the interview with the Resident Care Coordinator on 10/24/24 at 10:30am. Refer to the telephone interview with the Regional Senior Director of Wellness on 10/24/24 at 4:15pm. Refer to the interview with the Administrator on 10/25/24 at 9:10am.	D 611		

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D 611	Continued From page 31 2. Review of Resident #11's current FL2 dated 06/13/24 revealed diagnoses included type 2 diabetes mellitus, essential primary hypertension, and chronic kidney disease. Review of the facility's current census for 10/23/24 revealed Resident #11's room was located on the 200 hall. Review of Resident #11's skilled nursing facility discharge summary dated 06/13/24 revealed there was an order for fingerstick blood sugar (FSBS) check two times a day and as needed. Observation of the top drawer of the 200 hall medication cart on 10/23/24 at 11:44am revealed: -There was no glucometer available in the drawer with Resident #11's name. -There was an unlabeled black zippered pouch in the drawer. -There was an unlabeled glucometer and bottle of reagent strips inside the zippered pouch. Review of the manufacturer's user manual for the glucometer revealed the glucose monitoring system was intended to be used by a single person and should not be shared. Review of Resident #11's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Autoshield mis 30gx5mm (this is a brand name safety pen needle that attaches to an insulin pen) scheduled daily at 8:00pm. -There were administration notes for the Autoshield mis 30gx5mm with FSBS values documented on 09/09/24, 09/12/24, 09/13/24, 09/14/24, 09/15/24, 09/20/24, and 09/26/24.	D 611		

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D 611	Continued From page 32 -There was an entry for glargine-yfgn (a long-acting insulin used to lower blood sugar) 100u/ml scheduled daily at 8:00pm. -There were administration notes for the glargine-yfgn with FSBS values documented on 09/08/24, 09/14/24, and 09/28/24. Review of the unlabeled glucometer FSBS values recorded in the history from 09/08/24-09/30/24 revealed: -The date was 10/23/24 at 12:51pm when the glucometer was powered on 10/23/24 at 12:47pm. -There were 23 FSBS values recorded in the history of the glucometer dated 09/08/24-09/29/24. -There were 7 FSBS values recorded in the history of the glucometer that matched the FSBS values documented on Resident #11's September 2024 eMAR entries from 09/08/24-09/29/24. -On 09/08/24 at 7:48pm the FSBS was 153 and the documented FSBS on Resident #11's September eMAR glargine-yfgn entry administration note on 09/08/24 at 7:48pm was 153. -On 09/09/24 at 7:27pm the FSBS was 149 and the documented FSBS on Resident #11's September eMAR Autoshield mis 30gx5mm entry administration note on 09/09/24 at 7:15pm was 149. -On 09/12/24 at 7:24pm the FSBS was 187 and the documented FSBS on Resident #11's September eMAR Autoshield mis 30gx5mm entry administration note on 09/12/24 at 7:20pm was 187. -On 09/13/24 at 8:15pm the FSBS was 177 and the documented FSBS on Resident #11's September eMAR Autoshield mis 30gx5mm entry administration note on 09/13/24 at 8:09pm was 177.	D 611		

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D 611	Continued From page 33 -On 09/14/24 at 7:13pm the FSBS was 200 and the documented FSBS on Resident #11's September eMAR Autoshield mis 30gx5mm entry administration note on 09/14/24 at 7:09pm was 200. -On 09/15/24 at 8:06pm the FSBS was 182 and the documented FSBS on Resident #11's September eMAR Autoshield mis 30gx5mm entry administration note on 09/15/24 at 8:09pm was 182. -On 09/28/24 at 7:30pm the FSBS was 172 and the documented FSBS on Resident #11's September eMAR glargine-yfgn entry administration note on 09/28/24 at 7:25pm was 172. Review of Resident #11's October 2024 eMAR revealed: -There was an entry for Autoshield mis 30gx5mm scheduled daily at 8:00pm. -There were administration notes for the Autoshield mis 30gx5mm with FSBS values documented on 10/02/24, 10/05/24, 10/07/24, 10/12/24, 10/17/24, and 10/18/24. -There was an entry for Lantus (used to lower blood sugar) inject 12 units daily at bedtime scheduled at 8:00pm. -There were administration notes for the Lantus with FSBS values documented on 10/03/24, 10/08/24, 10/09/24, 10/10/24, 10/11/24, 10/12/24, 10/13/24, 10/20/24, and 10/21/24. -There was an entry for Sure Comfort safety lancet use to test blood every night at bedtime scheduled at 8:00pm with FSBS values documented on 10/04/24, 10/06/24, 10/13/24, 10/14/24, and 10/24/24. Review of the unlabeled glucometer FSBS values recorded in the history from 10/01/24-10/22/24 revealed:	D 611		

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D 611	Continued From page 34 -The date was 10/23/24 at 12:51pm when the glucometer was powered on 10/23/24 at 12:47pm. -There were 30 FSBS values recorded in the history of the glucometer dated 10/01/24-10/22/24. -There were 7 FSBS values recorded in the history of the glucometer that matched the FSBS values documented on Resident #11's October 2024 eMAR entries from 10/01/24-10/22/24. -On 10/03/24 at 7:58pm the FSBS was 173 and the documented FSBS on Resident #11's October eMAR Lantus entry administration note on 10/03/24 at 7:45pm was 173. -On 10/08/24 at 8:09pm the FSBS was 149 and the documented FSBS on Resident #11's October eMAR Lantus entry administration note on 10/08/24 at 8:01pm was 149. -On 10/09/24 at 8:13pm the FSBS was 197 and the documented FSBS on Resident #11's October eMAR Lantus entry administration note on 10/09/24 at 8:31pm was 197. -On 10/10/24 at 8:52pm the FSBS was 135 and the documented FSBS on Resident #11's October eMAR Lantus entry administration note on 10/10/24 at 8:48pm was 135. -On 10/11/24 at 7:40pm the FSBS was 184 and the documented FSBS on Resident #11's October eMAR Lantus entry administration note on 10/11/24 at 7:36pm was 184. -On 10/12/24 at 7:43pm the FSBS was 149 and the documented FSBS on Resident #11's October eMAR Lantus entry administration note on 10/12/24 at 7:39pm was 149. -On 10/13/24 at 7:40pm the FSBS was 166 and the documented FSBS on Resident #11's October eMAR Lantus entry administration note on 10/13/24 at 7:34pm was 166. Interview with the Administrator on 10/24/24 at	D 611		

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D 611	Continued From page 35 4:59pm revealed: -The MA told her the unlabeled glucometer observed in the top drawer of the 200 hall medication cart was a "house" glucometer. -The MA staff told her the unlabeled glucometer may have been used to check the FSBSs for Resident #11. Interview with Resident #11 on 10/25/24 at 10:15am revealed: -She received FSBS checks once a day before bed. -The MAs used a glucometer to collect her FSBS checks. -The glucometer the MAs used was stored on the medication cart. Refer to the interview with the Resident Care Coordinator on 10/24/24 at 10:30am. Refer to the telephone interview with the Regional Senior Director of Wellness on 10/24/24 at 4:15pm. Refer to the interview with the Administrator on 10/25/24 at 9:10am. 3. Review of Resident #2's current FL2 dated 11/01/23 revealed diagnoses included diabetes mellitus, chronic kidney disease stage 4, hypertension, chronic diastolic congestive heart failure, and sleep apnea. Review of the facility's current census for 10/23/24 revealed Resident #2's room was located on the 200 hall. Review of Resident #2's primary care provider (PCP) order dated 02/21/24 revealed FSBS checks at 7:00am, 11:00am, 5:00pm, and as	D 611		

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D 611	Continued From page 36 needed if symptoms not matching continuous glucose monitor reading. Review of Resident #2's PCP order dated 05/17/24 revealed continuous glucose monitor (CGM) remove and apply one sensor to the skin every 10 days to continuously monitor blood glucose. Review of Resident #2's PCP order dated 09/23/24 Sure Comfort safety lancet 30g use to test blood sugar four times a day at 8:00am, 12:00pm, 4:00pm, and 8:00pm. Observation of the top drawer of the 200 hall medication cart on 10/23/24 at 11:44am revealed: -There was a black hard case labeled with Resident #2's name with a glucometer and reagent strips inside. -There was an unlabeled black zippered pouch in the drawer. -There was an unlabeled glucometer and bottle of reagent strips inside the zippered pouch. Review of the manufacturer's user manual for the glucometer revealed the glucose monitoring system was intended to be used by a single person and should not be shared. Review of Resident #2's October 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Autoshield mis 30gx5mm to inject insulin four times daily scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There were administration notes for the Autoshield mis 30gx5mm with FSBS values documented on 10/14/24, 10/17/24, and 10/20/24. -There was an entry for FSBS test sugar at	D 611		

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D 611	Continued From page 37 bedtime scheduled at 8:00pm. -There were administration notes for the FSBS entry had FSBS values documented on nightly from 10/01/24-10/22/24 with the exceptions of 10/05/24, 10/09/24, and 10/10/24. -There was an entry for novolog flexpen check FSBS before meals per sliding scale scheduled at 7:30am, 11:30am, and 4:30pm. -There were administration notes for the novolog flexpen with FSBS values documented on 10/01/24-10/22/24 with the exceptions of 10/04/24, 10/08/24, 10/10/24, and 10/22/24. -There was an entry for Sure Comfort safety lancet use to test blood sugar four times daily scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There were administration notes for the Sure Comfort safety lancet with FSBS values documented on 10/06/24, 10/10/24, 10/14/24, 10/18/24, and 10/20/24. Review of the unlabeled glucometer FSBS values recorded in the history from 10/01/24-10/22/24 revealed: -The date was 10/23/24 at 12:51pm when the glucometer was powered on 10/23/24 at 12:47pm. -There were 30 FSBS values recorded in the history of the glucometer dated 10/01/24-10/22/24. -There were 2 FSBS values recorded in the history of the glucometer that matched the FSBS values documented on Resident #2's October 2024 eMAR entries from 10/01/24-10/22/24. -On 10/06/24 at 8:50pm the FSBS was 477 and the documented FSBS on Resident #2's October eMAR FSBS administration note on 10/06/24 at 9:19pm was 477. -On 10/14/24 at 8:13pm the FSBS was 363 and the documented FSBS on Resident #2's October	D 611		

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CHARTER SENIOR LIVING OF CHARLOTTE	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 611	Continued From page 38 eMAR FSBS administration note on 10/14/24 at 8:04pm was 363. Interview with Resident #2 on 10/24/24 at 12:07pm revealed: -There were a few times when his continuous glucose monitor (CGM) supplies had not arrived on time. -The staff had to collect a FSBS to check his blood sugar levels when his CGM was not working. -He could not remember the dates when the staff collected FSBS's. -He had heard staff say they were using the "house" glucometer to obtain his FSBS. -It had taken "awhile" to get his own glucometer. -When he first began using his CGM, there were two or three sensors that did not work. -Until they were able to get replacement sensors, the staff would have to do FSBS checks. Refer to the interview with the Resident Care Coordinator on 10/24/24 at 10:30am. Refer to the telephone interview with the Regional Senior Director of Wellness on 10/24/24 at 4:15pm. Refer to the interview with the Administrator on 10/25/24 at 9:10am. 4. Review of Resident #14's current FL2 dated 07/02/24 revealed diagnoses included type 2 diabetes mellitus, hypertension, and chronic kidney disease. Review of the facility's current census for 10/23/24 revealed Resident #14's room was located on the 200 hall.	D 611		

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D 611	Continued From page 39 Review of Resident #14's primary care provider (PCP) order dated 07/09/24 revealed blood sugar twice daily with meals. Observation of the top drawer of the 200 hall medication cart on 10/23/24 at 11:44am revealed: -There was a black zippered case labeled with Resident #14's name with a glucometer and reagent strips inside. -There was an unlabeled black zippered pouch in the drawer. -There was an unlabeled glucometer and bottle of reagent strips inside the zippered pouch. Review of the manufacturer's user manual for glucometer revealed the glucose monitoring system was intended to be used by a single person and should not be shared. Review of Resident #14's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for True metrix (brand name of glucometer test strips) test glucose use to check blood sugar twice daily with meals scheduled for 8:00am and 5:00pm. -There were 27 FSBS values recorded in the history of the glucometer dated 09/02/24-09/29/24. -There were 9 FSBS values recorded in the history of the glucometer that matched the FSBS values documented on the September eMAR from 09/01/24-09/30/24. -On 09/13/24 at 4:03pm the FSBS was 240 and the documented FSBS on Resident #14's September eMAR True metrix administration note on 09/13/24 at 4:32pm was 240. -On 09/14/24 at 7:06am the FSBS was 271 and the documented FSBS on Resident #14's September eMAR True metrix administration note	D 611		

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D 611	Continued From page 40 on 09/14/24 at 7:01am was 271. -On 09/15/24 at 7:53am the FSBS was 273 and the documented FSBS on Resident #14's September eMAR True metrix administration note on 09/15/24 at 7:47am was 273. -On 09/15/24 at 4:03pm the FSBS was 363 and the documented FSBS on Resident #14's September eMAR True metrix administration note on 09/15/24 at 4:05pm was 363. -On 09/16/24 at 7:26am the FSBS was 358 and the documented FSBS on Resident #14's September eMAR True metrix administration note on 09/16/24 at 7:38am was 358. -On 09/20/24 at 7:46am the FSBS was 261 and the documented FSBS on Resident #14's September eMAR True metrix administration note on 09/20/24 at 9:37am was 261. -On 09/24/24 at 7:42am the FSBS was 243 and the documented FSBS on Resident #14's September eMAR True metrix administration note on 09/24/24 at 8:36am was 243. -On 09/28/24 at 7:31am the FSBS was 259 and the documented FSBS on Resident #14's September eMAR True metrix administration note on 09/28/24 at 7:30am was 259. -On 09/29/24 at 7:17am the FSBS was 225 and the documented FSBS on Resident #14's September eMAR True metrix administration note on 09/29/24 at 7:11am was 225. Review of Resident #14's October 2024 eMAR revealed: -There was an entry for True metrix test glucose use to check blood sugar twice daily with meals scheduled for 8:00am and 5:00pm. -There were 30 FSBS values recorded in the history of the glucometer dated 10/01/24-10/22/24. -There were 7 FSBS values recorded in the history of the glucometer that matched the FSBS	D 611		

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D 611	Continued From page 41 values documented on the October eMAR from 10/01/24-10/22/24. -On 10/01/24 at 4:14pm the FSBS was 226 and the documented FSBS on Resident #14's October eMAR True metrix administration note on 10/01/24 at 4:24pm was 226. -On 10/06/24 at 3:22pm the FSBS was 181 and the documented FSBS on Resident #14's October eMAR True metrix administration note on 10/06/24 at 4:00pm was 181. -On 10/07/24 at 4:22pm the FSBS was 218 and the documented FSBS on Resident #14's October eMAR True metrix administration note on 10/07/24 at 5:06pm was 218. -On 10/10/24 at 8:08am the FSBS was 244 and the documented FSBS on Resident #14's October eMAR True metrix administration note on 10/10/24 at 8:08am was 244. -On 10/13/24 at 7:37am the FSBS was 211 and the documented FSBS on Resident #14's October eMAR True metrix administration note on 10/13/24 at 7:31am was 211. -On 10/14/24 at 3:57pm the FSBS was 344 and the documented FSBS on Resident #14's October eMAR True metrix administration note on 10/14/24 at 5:06pm was 344. -On 10/18/24 at 3:33pm the FSBS was 400 and the documented FSBS on Resident #14's October eMAR True metrix administration note on 10/18/24 at 4:14pm was 400. Refer to the interview with the Resident Care Coordinator on 10/24/24 at 10:30am. Refer to the telephone interview with the Regional Senior Director of Wellness on 10/24/24 at 4:15pm. Refer to the interview with the Administrator on 10/25/24 at 9:10am.	D 611		

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D 611	Continued From page 42 5. Review of Resident #12's current FL2 dated 04/29/24 revealed diagnoses included dementia, controlled hypertension, and diabetes mellitus type 2. Review of Resident #12's hospital discharge summary dated 07/17/24 revealed insulin glargine 100u/ml 25 units daily at bedtime. Review of Resident #12's PCP order dated 09/20/24 revealed Lantus 30 unit every night at bedtime. Observation of the Special Care Unit (SCU) medication cart on 10/23/24 at 12:05pm revealed: -There was an unlabeled black zipper pouch in the top drawer of the medication cart. -There was an unlabeled glucometer stored in the unlabeled zippered pouch. Interview with the SCU MA on 10/23/24 at 12:05pm revealed: -She believed the unlabeled glucometer belonged to Resident #12 who used to get FSBS checks daily at night. -She thought the FSBS order for that resident had been discontinued. -She did not know why the unlabeled glucometer was still on the medication cart. Review of the manufacturer's user manual for the glucometer revealed the glucose monitor was intended to be used by a single person and should not be shared. Review of the unlabeled glucometer FSBS values recorded in the history from 09/18//24-10/15/24 revealed the date was 10/16 (no year) at 6:08pm when the glucometer was powered on 10/23/24	D 611		

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D 611	Continued From page 43 at 12:29pm. Review of Resident #12's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus inject 30 units every night at bedtime scheduled for 8:00pm. -There were 3 FSBS values recorded in the history of the unlabeled glucometer dated 09/18/24, 09/21/24, and 09/30/24. -There was 1 FSBS values recorded in the history of the glucometer that matched the FSBS values documented on the September 2024 eMAR. -On 09/21/24 at 4:40pm the FSBS was 414 and the documented FSBS on the September 2024 eMAR Lantus administration note on 09/21/24 at 7:31pm was 414. Review of Resident #12's October 2024 eMAR revealed: -There was an entry for Lantus 100u/ml inject 30 units every night at bedtime scheduled for 8:00pm. -There were 4 FSBS values recorded in the history of the unlabeled glucometer dated 10/03/24, 10/10/24, 10/12/24, and 10/15/24. -There was 1 FSBS value recorded in the history of the glucometer that matched the FSBS values documented on the October 2024 eMAR. -On 10/15/24 at 5:48pm the FSBS was 404 and the documented FSBS on the October 2024 eMAR Lantus administration note on 10/15/24 at 7:26pm was 404. Interview with the Resident Care Coordinator (RCC) on 10/24/24 at 10:30am revealed Resident #12 did not have a current order for FSBS testing. Interview with a medication aide (MA) on 10/24/24 at 3:50pm revealed:	D 611		

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D 611	Continued From page 44 -There were residents who were ordered long acting insulin, but did not have an entry on the eMAR to check a FSBS prior to administering the long acting insulin. -She did not want to administer insulin without knowing what the FSBS was prior to administering insulin. -She would check a FSBS prior to administering insulin and document the FSBS result in the administration notes of the insulin entry in the eMAR. -She checked the FSBS because she did not want a resident's blood sugar to "bottom out." Based on observations, interviews, and record reviews it was determined Resident #12 was not interviewable Refer to the interview with the Resident Care Coordinator on 10/24/24 at 10:30am. Refer to the telephone interview with the Regional Senior Director of Wellness on 10/24/24 at 4:15pm. Refer to the interview with the Administrator on 10/25/24 at 9:10am. Interview with the Resident Care Coordinator (RCC) on 10/24/24 at 10:30am revealed: -The Health and Wellness Director (HWD) ordered a box of glucometers for "house meter stock." -Once the staff opened a new glucometer, they were supposed to assign it to the resident they used it on. -The MAs were not supposed to use a one meter to check multiple resident FSBSs. -The medication carts were audited by the pharmacy at every cycle fill.	D 611		

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D 611	Continued From page 45 -The MAs were also required to do weekly cart audits. -The HWD told everyone to put a new glucometer on the medication cart "just in case." -The new glucometer would remain unlabeled until it was used the first time then label and use only for that resident. -The HWD was not available for interview. Telephone interview with the Regional Senior Director of Wellness on 10/24/24 at 4:15pm revealed: -The facility's policy was every resident with orders for FSBS checks had their own glucometer. -The MAs were trained to not share glucometers. -If there had been a problem with a battery not working in a resident's glucometer, the staff knew there were extra batteries in the Administrator's office. -If the available batteries did not fit the specific glucometer, the MA should have communicated the issue to the RCC and the Administrator and they would have gone out and bought a battery to fit Resident #13's glucometer. Interview with the Administrator on 10/25/24 at 9:10am revealed: -The MAs should not be sharing glucometers between residents. -All residents should have their own 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 glucometers between Residents #2, #11, #13, and #14 . This failure was detrimental to the health, safety, and	D 611		

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D 611	Continued From page 46 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 October 23, 2024 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 09, 2024.	D 611		