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	HAL081001	A. BUILDING: _____ B. WING _____	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR REST HOME	160 HEALTH CARE DRIVE RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Rutherford County Department of Social Services completed an annual, follow-up and complaint investigation survey from 01/02/25 - 01/03/25 and 01/06/25.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a safe environment free from hazards related to the presence of live bed bugs in residents' rooms. The findings are: Observation of resident room 14a during initial tour on 01/02/25 at 10:25am revealed: -There was a small, brown bed bug crawling across the resident's pillow. -The resident picked up the bed bug and dropped it onto the bed linen. -The resident looked around but could not find the bed bug. -The walls in the corner of the room near the ceiling had black colored speckles dispersed around the walls.	D 079		

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Interview with the resident residing in 14a on 01/02/25 at 10:25am revealed:
-She thought the bug crawling across her pillow was a gnat.
-She saw bugs in her room sometimes.
-The Maintenance Director sprayed her room about a month ago to help get rid of the bugs.
-The personal care aide (PCA) changed her sheets this morning and told her it would help get rid of the bugs.

Observation in a second resident's room on 01/03/25 at 2:53pm revealed there was an unidentifiable brown bug carcass lying on the bottom sheet with black specks dispersed on the sheet.

Observation in resident room 12a on 01/06/25 at 1:35pm revealed there was a small, brown bed bug crawling up the wall from the headboard area.

Interview with the resident in room 12a on 01/06/25 at 1:35pm revealed:
-She had never seen any bugs in her room, but staff told her they had seen some.
-She did not know what kind of bugs were in her room.
-The Maintenance Director sprayed bug spray in her room about 3 times in the past 1 ½ -2 months.
-The bugs were biting her at night, and she used to itch "really bad".
-She did not think she had been bitten recently.

Interview with a third resident on 01/02/25 at 9:06am revealed:
-She had resided at the facility for 3 years.
-She had "bugs" in her room last week and the Maintenance Director sprayed a bug spray in her

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room.
-She had to stay out of her room the day maintenance treated her room but was allowed to go back in to sleep that night.
-She did not know what kind of bugs were in her room.
-The Maintenance Director sprayed bug spray in her room weekly for the past 2 weeks.

Interview with a fourth resident on 01/02/25 at 9:19am revealed:
-The Maintenance Director sprayed her room last week with bug spray.
-She did not know what kind of bugs were in the facility.

Interview with a fifth resident on 01/02/25 at 9:30am revealed:
-One of the male staff members sprayed her room 1-2 months ago for insects.
-She had to leave her room for a couple of hours after her room was treated with a bug spray.
-She saw "little bugs" in the facility sometimes but did not know what kind of bugs they were.
-She was not aware of any bugs in her room.

Interview with a sixth resident on 01/02/25 at 10:03am revealed:
-The Maintenance Director sprayed bug spray in her room on 12/30/24 and told her he was spraying for "bed bugs".
-She saw him spraying in different rooms for the last 2 months.
-She thought the residents' rooms on the other side of the hallway were the rooms that had bed bugs.

Interview with a seventh resident on 01/02/25 at 10:09am revealed:
-She had not seen any bed bugs in her room.

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D 079	Continued From page 3 -The facility staff were trying to get rid of the bed bugs in the facility. Interview with a medication aide (MA) on 01/03/25 at 11:58am revealed: -She helped the PCAs with providing personal care to residents and changing linens if needed. -The facility had issues with bed bugs for a "few" months. -She had not seen any bed bugs in about a month, "we have bed bugs cured". -The Maintenance Director sprayed every 2 weeks for prevention of bed bugs or when any bed bugs were seen in the facility. -When bed bugs were seen in a resident's room, she helped bag up the resident's clothing and put it in the dryer because the heat would kill the bed bugs. -A pest control company came to the facility in December 2024 and sprayed around the facility. Interview with the Administrator on 01/03/25 at 12:35pm revealed: -She contracted a local pest control company to treat the facility "for everything" including bed bugs monthly. -The last treatment for pest control including bed bugs was provided on 12/05/24. Review of invoices from the facility's contracted local pest control company revealed: -On 11/06/24, general pest control services including roaches were provided to the facility. -On 12/05/24, there was a bill for $223 for services with no description of the services provided. Interview with the Maintenance Director on 01/03/25 at 2:35pm revealed: -He sprayed every room at the facility weekly.	D 079		

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-He used a bed bug spray purchased from a local store to treat bed bugs.
-He had been spraying the rooms at the facility for bed bugs for the past 2-3 weeks.
-An employee with the facility's contracted pest control company showed him where to spray to treat bed bugs including the baseboards, cracks in the walls, or any seams.
-A resident in room 7(b) was the only resident that reported having bed bugs in his room.
-He was not aware of any other residents' that complained of having bed bugs in their rooms.

Observation of the bed bug treatment spray used by the Maintenance Director on 01/03/25 at 2:36pm revealed a one-gallon plastic container labeled with a brand name and "bed bug killer egg kill treatment" printed on the label that was available for purchase at local stores.

Telephone interview with a secretary from the facility's contracted local pest control company on 01/06/25 at 9:54am revealed:
-They provided general pest control services monthly at the facility.
-The last general pest control services treatment was completed on 12/05/24.
-The facility did not request treatment for bed bug infestation and bed bug treatments were not included in the general pest control services because bed bugs would have to be treated differently.
-A service technician with the company in another state specialized in bed bug treatment and would have to treat the facility for bed bugs if the service was needed.

Telephone interview with a service technician from the facility's contracted pest control company specializing in bed bug treatments on

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D 079	Continued From page 5 01/06/25 at 10:13am revealed: -He did not provide bed bug treatment services to assisted living facilities because the entire wing or building would have to be blocked off. -Assisted living facilities would need to have heat treatment services provided to kill the bed bugs, but his company did not provide heat treatment. -The facility did not contact him about having any issues with a bed bug infestation. Telephone interview with a service technician from the facility's contracted pest control company on 01/06/25 at 2:15pm revealed: -He visited the facility monthly to perform general pest control treatments. -He alternated using 3 different chemicals for pest control. -The chemicals he used for general pest control would also treat a bed bug infestation. -He last treated the rooms known to have bed bugs in the facility when he completed the generalized pest control in December 2024 but could not remember what day. -The chemical in bed bug treatment sprays purchased from local stores were not generally strong enough to treat bed bug infestations and professional treatment sprays must be used. Interview with the Administrator on 01/06/25 at 12:28pm revealed: -She knew some residents had bed bugs in the facility. -The last resident to complain to her about being bitten by bed bugs was the resident in room 12a. -The facility had a bed bug infestation for the past 6 months. -She completed an online training course regarding the treatment of bed bug infestations about 6 months ago when she discovered there were bed bugs in the facility.	D 079		

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D 079	Continued From page 6 -She had thrown out 6 mattresses and replaced the mattresses with new ones due to bed bugs. -A service technician from the facility's contracted pest control company that comes out monthly and the Maintenance Director pulled off the rubber baseboard strip in room 12 last week and there were bed bugs behind it. -She was not paying the facility's contracted pest control company to treat for a bed bug infestation, but the service technician that comes monthly to treat the facility for generalized pest control had been treating the bed bugs "on the side". -The Maintenance Director also sprayed bed bug treatment purchased by the facility when anyone saw any bed bugs. -The bed bug infestation in the facility was treated for several months now. -Most of the bed bugs were seen during the daytime hours; "we don't really see them at night". -She had staff throw away some of the sheets and pillowcases due to the bed bug infestation and the bed linens were changed twice weekly on shower days. -She had staff take all the residents' clothes that had bed bugs in the room to the local laundry mat and put the clothes in a dryer so that the heat would kill the bed bugs.	D 079		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents.	D 292		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to maintain a record of menu substitutions indicating what food was served to the residents.

The findings are:

Review of the lunch menu for 01/02/25 revealed the menu consisted of 4 ounces (oz) oven fried fish, half a baked potato, ½ cup cooked frozen spinach, a wheat roll, and ½ cup mandarin oranges in juice.

Observation of the lunch meal service on 01/02/25 from 11:45am to 12:25pm revealed the residents were served oven baked fish, half a baked potato, cooked spinach, a slice of white bread, and pear slices in juice.

Review of the menu substitutions notebook on 01/02/25 at 11:43am revealed:
-There was a piece of notebook paper dated 07/24/24 with documentation of substitutions made at breakfast consisting of scrambled eggs, sausage and liver mush, biscuits, and grits and lunch consisted of ham and pinto beans, cornbread, greens, and pears.
-There was a September 2024 menu substitutions calendar sheet with documentation

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of substitutions for breakfast, lunch, and dinner on 09/09/24 and 09/10/24.
-There was an October 2024 menu substitutions calendar sheet with no documentation of any substitutions.
-There was a November 2024 menu substitutions calendar sheet with no documentation of any substitutions.
-There was a December 2024 menu substitutions calendar sheet with no documentation of any substitutions.

Review of the menu substitutions notebook on 01/03/25 at 10:40am revealed there were no substitutions documented for the lunch meal service served on 01/02/25.

Interview with the cook on 01/03/25 at 11:05am revealed:
-He did not write down any substitutions for the lunch meal served on 01/02/25 because he served what the facility Manager wrote down for him to serve.
-The menu was available in the kitchen, but he used what was written down on a piece of paper to prepare the meal.
-The facility Manager wrote down on a piece of paper each day what to serve for each meal.
-He was not told by the facility Manager to document the substitutions that were made if he served what the facility Manager instructed him to serve.

Interview with a second cook on 01/06/25 at 10:37am revealed:
-She worked as a cook for the facility for about a month.
-The other cook and the facility Manager "went over some stuff" with her for her training, but did not instruct her to document substitutions on the

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substitutions log.
-There were no substitution logs for December 2024 or January 2024 in the substitution notebook.
-She always prepared the meals for the residents by using the paper the facility Manager filled out each day for what to serve the residents.
-She did not compare what was written down on the paper by the facility Manager to the menu, so she did not know she was supposed to document any substitutions if they were different.

Interview with the facility Manager on 01/06/24 at 10:47am revealed:
-He wrote down on a piece of paper what the cooks should serve each day for breakfast, lunch, and dinner.
-He was responsible for ordering the facility's groceries each week.
-If an item was unavailable, he would write down what the cook should substitute instead.
-The cooks had not had any type of formal training to work in the kitchen.
-Any substitutions made were supposed to be documented in the substitution's notebook.
-He did not know that substitutions were not being documented in the substitution notebook.

Interview with the Administrator on 01/06/25 at 12:28pm revealed:
-She did not know that the cooks were not documenting menu substitutions in the substitution notebook.
-Staff knew they were supposed to document any substitutions in the notebook.
-She and the facility Manager were responsible for checking the substitutions notebook to make sure it was being documented in accurately, but it was missed because they did not "pay enough attention" because of the recent holidays.

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D 295	10A NCAC 13F .0904(c)(6) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (6) Menus for all therapeutic diets shall be planned or reviewed by a licensed dietitian/nutritionist. The facility shall maintain verification of the licensed dietitian/nutritionist's approval of the therapeutic diets. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there was a therapeutic diet menu approved by a licensed dietician available for staff guidance for 5 of 5 sampled residents (#1, #2, #3, #4, and #5) who were ordered a regular diet with no sugar added and sugar-free snacks (#1), diabetic diet (#2), no concentrated sweets diet (#3), and regular/2,000 calorie American Diabetic Association (ADA) diet (#4 & #5). The findings are: Observation in the kitchen on 01/02/25 at 9:38am revealed there was a list posted on the wall with "diabetes" typed on the paper and 8 resident names listed underneath. Review of the therapeutic diet menus on 01/02/25 at 9:45am revealed there was no therapeutic diet	D 295		

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menu available for a regular diet, no sugar added and sugar-free snacks, diabetic diet, no concentrated sweets diet, or a regular/2,000 calorie ADA diet.

Interview with a cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am revealed:
-He did not use the therapeutic diets menu book for guidance to prepare meals.
-The facility Manager wrote down on a piece of paper each day what foods for him to prepare for each meal.
-All of the residents in the facility had orders for a regular diet and were served a regular diet.
-All meals were prepared the same and served the same.
-The facility had 2 residents with diabetes but were served a regular diet because he was not instructed to use alternative foods.
-He did not know what therapeutic diet menus were available because he did not use the menus for guidance to prepare meals.

Interview with the facility Manager on 01/02/25 at 2:40pm revealed:
-He was responsible for keeping an updated therapeutic diet list in the kitchen for staff so that meals could be prepared using guidance from the therapeutic diet menu book.
-The cooks were not formerly trained in the kitchen.
-The cooks did not know how to prepare therapeutic diets by using the therapeutic diet menu for guidance so he wrote down each day what meal for the cooks to prepare.
-The facility did not have a therapeutic diet menu for a diabetic diet, no concentrated sweets diet, or 2000 calorie ADA diet.
-The menus the facility currently used were sample menus provided by a therapeutic diet

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D 295	Continued From page 12 menu supply company. -In order for the facility to have access to all of the menus for therapeutic diets signed by a registered dietician, the facility would have to pay the diet menu supply company annually. Telephone interview with a customer service representative from the therapeutic diet menu supply company on 01/06/25 at 4:26pm revealed: -A representative from the company visited the facility in the fall of 2024 to show the Administrator sample menus created by a registered dietician. -The Administrator did not purchase the menus including the therapeutic diet menus, but the sample set (7 binders of menus) was given to the Administrator at no charge for the Administrator to look over and decide if the menus from the company wanted to be purchased by the facility. -If the menus were purchased through the company, any therapeutic diet menu could be provided including diabetic diet, 2000 calorie ADA diet, and no concentrated sweets diet. -The menu supply company had a dietician that created the therapeutic diet menus but no longer signed the menus. Interview with the Administrator on 01/06/25 at 12:28pm revealed: -She was provided a set of therapeutic diet menus from a menu supply company sometime in the fall of 2024. -She thought all therapeutic diet menus were included in the binders and all the diets were signed by a dietician.	D 295		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service	D 296		

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D 296	Continued From page 13 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have matching therapeutic menus for food service staff guidance for 5 of 5 sampled residents (#1, #2, #3, #4 and #5) with physician orders for a regular diet, no sugar added and sugar free snacks (#1), diabetic diets (#2), no concentrated sweets diet (#3), and 2,000 calorie American Diabetic Association (ADA) diet (#4 and #5). The findings are: 1. Review of Resident #1's current FL2 dated 08/16/24 revealed diagnoses included diabetes, dementia, gastric reflux disease and heart failure. Review of Resident #1's primary care provider (PCP) order dated 12/17/24 revealed: -There was an order for a regular diet, no sugar added. -There was an order for sugar free snacks. Observation of the lunch meal service on 01/02/25 from 11:45am through 12:25pm revealed Resident #1 received baked fish, one slice of white sandwich bread, half a baked potato with one tablespoon margarine, cooked spinach,	D 296		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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and canned sliced pears in syrup.

It could not be determined if Resident #1 was served the appropriate sugar free diet because there was no therapeutic diet menu available for staff guidance.

Refer to the interview with the cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am.

Refer to the interview with the facility Manager on 01/02/25 at 2:40pm.

Refer to the telephone interview with Resident #1's primary care provider (PCP) on 01/03/25 at 3:10pm.

Refer to the interview with a customer service representative from the therapeutic diet menu supply company on 01/06/25 at 4:26pm.

Refer to the interview with the Administrator on 01/06/25 at 12:28pm.

2. Review of Resident #2's current FL2 dated 05/17/24 revealed diagnoses included legal blindness, type 2 diabetes uncontrolled, and contractures.

Review of Resident #2's primary care provider (PCP) order dated 05/24/24 revealed regular diet/regular 2000 ADA diet.

Review of Resident #2's PCP order dated 11/12/24 revealed diabetic diet.

Review of Resident #2's PCP order dated 12/17/24 revealed diabetic diet.

Observation of the lunch meal service on

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D 296	Continued From page 15 01/02/25 from 11:45am through 12:25pm revealed Resident #2 received baked fish, one slice of white sandwich bread, half a baked potato with one tablespoon margarine, cooked spinach, and canned sliced pears in syrup. It could not be determined if Resident #2 was served the appropriate diabetic diet because there was no therapeutic diet menu available for staff guidance. Refer to the interview with the cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am. Refer to the interview with the facility Manager on 01/02/25 at 2:40pm. Refer to the telephone interview with Resident #2's primary care provider (PCP) on 01/03/25 at 3:10pm. Refer to the interview with a customer service representative from the therapeutic diet menu supply company on 01/06/25 at 4:26pm. Refer to the interview with the Administrator on 01/06/25 at 12:28pm. 3. Review of Resident #3's current FL2 dated 02/27/24 revealed diagnoses included diabetes, memory loss, gastric reflux disease and hyperlipidemia. Review of Resident #3's primary care provider (PCP) order dated 03/15/24 revealed an order for a no concentrated sweets diet. Observation of the lunch meal service on 01/02/25 from 11:45am through 12:25pm revealed Resident #3 received baked fish, one	D 296		

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slice of white sandwich bread, half a baked potato with one tablespoon margarine, cooked spinach, and canned sliced pears in syrup.

It could not be determined if Resident #3 was served the appropriate no concentrated sweets diet because there was no therapeutic diet menu available for staff guidance.

Refer to the interview with the cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am.

Refer to the interview with the facility Manager on 01/02/25 at 2:40pm.

Refer to the telephone interview with Resident #3's primary care provider (PCP) on 01/03/25 at 3:10pm.

Refer to the interview with a customer service representative from the therapeutic diet menu supply company on 01/06/25 at 4:26pm.

Refer to the interview with the Administrator on 01/06/25 at 12:28pm.

4. Review of Resident #4's current FL2 dated 06/21/24 revealed diagnoses included post-polio syndrome, hypertension, chronic pain, and cognitive communication deficit.

Review of Resident #4's physician's order dated 04/24/24 revealed there was an order for a regular/2000 calorie American Diabetic Association (ADA) diet.

Observation of the lunch meal service on 01/02/25 from 11:45am through 12:25pm revealed Resident #4 received baked fish, one slice of white sandwich bread, half a baked potato

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with one tablespoon margarine, and cooked spinach.

It could not be determined if Resident #4 was served the appropriate 2000 calorie ADA diet because there was no therapeutic diet menu available for staff guidance.

Refer to the interview with the cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am.

Refer to the interview with the facility Manager on 01/02/25 at 2:40pm.

Refer to the telephone interview with Resident #4's primary care provider (PCP) on 01/03/25 at 3:10pm.

Refer to the interview with a customer service representative from the therapeutic diet menu supply company on 01/06/25 at 4:26pm.

Refer to the interview with the Administrator on 01/06/25 at 12:28pm.

5. Review of Resident #5's current FL2 dated 12/03/24 revealed diagnoses included schizoaffective disorder and depressive type personality disorder.

Review of Resident #5's primary care provider (PCP) order dated 12/03/24 revealed an order for a regular/2,000 calorie American Diabetic Association (ADA) diet.

Observation of the lunch meal service on 01/02/25 from 11:45am through 12:25pm revealed Resident #5 received a sandwich with ham and cheese slices, half a baked potato with one tablespoon margarine, cooked spinach, and

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D 296	Continued From page 18 canned sliced pears in syrup. It could not be determined if Resident #5 was served the appropriate 2,000 calorie ADA diet because there was no therapeutic diet menu available for staff guidance. Refer to the interview with the cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am. Refer to the interview with the facility Manager on 01/02/25 at 2:40pm. Refer to the telephone interview with Resident #5's primary care provider (PCP) on 01/03/25 at 3:10pm. Refer to the interview with a customer service representative from the therapeutic diet menu supply company on 01/06/25 at 4:26pm. Refer to the interview with the Administrator on 01/06/25 at 12:28pm. _____ Interview with a cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am revealed: -He did not use the therapeutic diet menu book for guidance to prepare meals. -The facility Manager wrote down on a piece of paper each day what foods for him to prepare for each meal. -He was told by the facility Manager that all of the residents in the facility had orders for a regular diet and were served a regular diet. -All meals were prepared the same and served the same. -The facility had 2 residents with diabetes but were served a regular diet because the facility Manager told him all the residents had regular diets ordered.	D 296		

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D 296	Continued From page 19 -He did not know what therapeutic diet menus were available because he did not use the menus for guidance to prepare meals. Interview with the facility Manager on 01/02/25 at 2:40pm revealed: -He was responsible for keeping an updated therapeutic diet list in the kitchen for staff so that meals could be prepared using guidance from the therapeutic diet menu book. -He thought all the residents had orders for a regular diet. -He was hired about 4 months ago and thought he asked the primary care provider (PCP) to order all of the residents a regular diet because there was not enough kitchen staff to prepare different types of diets. -The cooks were not formerly trained in the kitchen. -The cooks did not know how to prepare therapeutic diets by using the therapeutic diet menu for guidance so he wrote down each day what meal for the cooks to prepare. -He used the diet menu provided by the menu supply company to order groceries and write down for the kitchen staff what meals to prepare and serve each day. -The facility did not have a therapeutic diet menu for a diabetic diet, no concentrated sweets diet, or 2000 calorie ADA diet. -The menus the facility currently used were sample menus provided by a therapeutic diet menu supply company. -In order for the facility to have access to all of the menus for therapeutic diets, the facility would have to pay the diet menu company annually. Telephone interview with Resident #1, #2, #3, #4, and #5's primary care provider (PCP) on 01/03/25 at 3:10pm revealed:	D 296		

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D 296	Continued From page 20 -She ordered the therapeutic diets for the residents to help control blood glucose levels. -It was important for each resident to receive the correct diet ordered. -If the residents were not served the correct diabetic diet, no concentrated sweets, or 2000 cal ADA diet it could increase blood glucose levels and long term would increase the complications of diabetes such as diabetic neuropathy, diabetic retinopathy, or chronic kidney disease. -Elevated blood glucose levels could also cause unnecessary hospitalizations. -The facility did not contact her to see if any diet orders could be changed to a regular diet. Telephone interview with a customer service representative from the therapeutic diet menu supply company on 01/06/25 at 4:26pm revealed: -A representative from the company visited the facility in the fall of 2024 to show the Administrator sample menus created by a registered dietician. -The Administrator did not purchase the menus including the therapeutic diet menus but the sample set (7 binders of menus) was given to the Administrator at no charge for the Administrator to look over and decide if the menus from the company wanted to be purchased by the facility. -If the menus were purchased through the company, any therapeutic diet menu could be provided including diabetic diet, 2000 calorie ADA diet, and no concentrated sweets diet. Interview with the Administrator on 01/06/25 at 12:28pm revealed: -She did not know the cooks were not using the therapeutic diet menus for guidance to prepare meals. -She was provided a set of therapeutic diet menus from a menu supply company sometime	D 296		

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D 296	Continued From page 21 in the fall of 2024. -She thought all therapeutic diet menus were included in the binders. -Her and the facility Manager were responsible for making sure the therapeutic diet list was updated in the kitchen for staff to reference but it was "missed" because it was busy due to the holidays.	D 296		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at each meal service for residents in addition to other beverages. The findings are: Review of the facility's census on 01/02/25 revealed a census of 32 residents. Observation of the lunch meal service on 01/02/25 from 11:45am through 12:25pm revealed: -There were 21 residents present for the lunch	D 306		

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meal service.
-The beverages were served by the cook from a beverage cart and consisted of either coffee or fruit punch drink.
-None of the 21 residents were served or offered water.

Interview with a resident on 01/02/25 at 12:27pm revealed:
-He was served one cup of fruit punch drink for lunch and he was still thirsty.
-The facility staff only offered coffee or the fruit punch to drink with meals.
-He liked water and would like to have water with his meal.

Interview with a cook on 01/02/25 at 12:42pm revealed:
-He was responsible for serving the drinks at meal times along with the food.
-He gave one resident water in her personal drink mug because she asked for it.
-He did not serve water to any of the other residents because they did not drink water.
-The residents just had to ask for water and he would give water to them.

Interview with a second cook on 01/06/25 at 10:37am revealed:
-She was responsible for serving the residents drinks during the meal service.
-She did not serve the residents water unless they asked for it.
-There were not enough cups to serve each resident a drink during meal times and some residents had to use their own personal cups to drink out of.
-She had 25 clean cups, 3 cups were being washed in the dishwasher, and there was a cup in 2 different resident rooms (30 cups total).

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D 306	Continued From page 23 Interview with the facility Manager on 01/06/25 at 12:24pm revealed: -He knew there were not enough cups in the facility to serve each resident a drink with each meal service and a glass of water with each meal. -Some of the residents drink out of their own personal cups. Interview with the Administrator on 01/06/25 at 12:28pm revealed: -She knew the facility was supposed to serve water with each meal. -She previously told staff to serve water with each meal. -She knew she did not have enough cups to serve each resident a drink and also a glass of water for at least a week but she did not "get around" to ordering new cups online. -Some residents drink from their own cups.	D 306		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and	D 309		

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interviews, the facility failed to maintain an accurate therapeutic diet list for guidance of food service staff for 5 of 5 sampled residents (#1, #2, #3, #4, and #5) who had orders for a regular with no sugar added diet and sugar-free snacks (#1), diabetic diet (#2), no concentrated sweets diet (#3), and regular/2,000 calorie American Diabetic Association (ADA) diet (#4 & #5).

The findings are:

Observation in the kitchen on 01/02/25 at 9:38am revealed there was a list posted on the wall with "diabetes" typed on the paper and 8 resident names listed underneath, and no therapeutic diets were specified.

Interview with a cook on 01/02/25 at 11:40am revealed:
-The list posted on the wall with "diabetes" and 8 resident names printed on it was a therapeutic diet order list made by the former kitchen supervisor.
-All the residents residing in the facility were ordered a regular diet.

1. Review of Resident #1's current FL2 dated 08/16/24 revealed diagnoses included diabetes, dementia, gastric reflux disease and heart failure.

Review of Resident #1's primary care provider (PCP) order dated 12/17/24 revealed:
-There was an order for a regular diet with no sugar.
-There was an order for snacks with no sugar.

Refer to the interview with the cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am.

Refer to the interview with the facility Manager on

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D 309	Continued From page 25 01/03/25 at 8:54am. Refer to the interview with the medication aide (MA) supervisor on 01/03/25 at 11:12am. Refer to the interview with the Administrator on 01/06/25 at 12:28pm. 2. Review of Resident #2's current FL2 dated 05/17/24 revealed diagnoses included legal blindness, type 2 diabetes uncontrolled, and contractures. Review of Resident #2's primary care provider (PCP) order dated 05/24/24 revealed regular diet/regular 2000 ADA diet. Review of Resident #2's PCP order dated 11/12/24 revealed diabetic diet. Review of Resident #2's PCP order dated 12/17/24 revealed diabetic diet. Refer to the interview with the cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am. Refer to the interview with the facility Manager on 01/03/25 at 8:54am. Refer to the interview with the medication aide (MA) supervisor on 01/03/25 at 11:12am. Refer to the interview with the Administrator on 01/06/25 at 12:28pm. 3. Review of Resident #3's current FL2 dated 02/27/24 revealed diagnoses included diabetes, memory loss, gastric reflux disease and hyperlipidemia.	D 309		

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D 309	Continued From page 26 Review of Resident #3's primary care provider (PCP) order dated 03/15/24 revealed an order for a no concentrated sweets diet. Refer to the interview with the cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am. Refer to the interview with the facility Manager on 01/03/25 at 8:54am. Refer to the interview with the medication aide (MA) supervisor on 01/03/25 at 11:12am. Refer to the interview with the Administrator on 01/06/25 at 12:28pm. 4. Review of Resident #4's current FL2 dated 06/21/24 revealed diagnoses included post-polio syndrome, hypertension, chronic pain, and cognitive communication deficit. Review of Resident #4's primary care provider (PCP) order dated 04/24/24 revealed there was an order for a regular/2000 calorie American Diabetic Association (ADA) diet. Refer to the interview with the cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am. Refer to the interview with the facility Manager on 01/03/25 at 8:54am. Refer to the interview with the medication aide (MA) supervisor on 01/03/25 at 11:12am. Refer to the interview with the Administrator on 01/06/25 at 12:28pm. 5. Review of Resident #5's current FL2 dated 12/03/24 revealed diagnoses included	D 309		

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D 309	Continued From page 27 schizoaffective disorder and depressive type personality disorder. Review of Resident #5's primary care provider (PCP) order dated 12/03/24 revealed an order for a regular/2000 calorie American Diabetic Association (ADA) diet. Refer to the interview with the cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am. Refer to the interview with the facility Manager on 01/03/25 at 8:54am. Refer to the interview with the medication aide (MA) supervisor on 01/03/25 at 11:12am. Refer to the interview with the Administrator on 01/06/25 at 12:28pm. _____ Interview with a cook on 01/02/25 at 12:42pm and 01/03/25 at 11:05am revealed: -All the residents in the facility had orders for a regular diet and were served a regular diet. -All meals were prepared the same and served the same. -The facility had 2 residents with diabetes but were served a regular diet because he was not instructed to use alternative foods. -The facility Manager was responsible for informing him if a resident's diet order changed. Interview with the facility Manager on 01/03/25 at 8:54am revealed: -He was responsible for keeping an updated therapeutic diet list posted in the kitchen since the former kitchen supervisor left the position. -There was not a therapeutic diet order list in the kitchen for guidance of staff because he thought all the residents had regular diet orders.	D 309		

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D 309	Continued From page 28 -He was responsible for reviewing and clarifying all orders including diet orders in the residents' records. Interview with the medication aide (MA) supervisor on 01/03/25 at 11:12am revealed: -She was responsible for reviewing all new orders and making sure the diet order was accurate on the FL2s. -She was responsible for letting the kitchen staff know when a diet order changed by adding the resident to the therapeutic diet list. -The residents on the therapeutic diet list in the kitchen under the section labeled "diabetes" were all supposed to be on a diabetic diet and low carbohydrates. -She had not changed anything on the therapeutic diet order list yet because she had only worked in the position as MA supervisor for 2 weeks. Interview with the Administrator on 01/06/25 at 12:28pm revealed: -Her and the facility Manager were responsible for reviewing all orders including diet orders and clarifying the order with the primary care provider (PCP) if needed. -Her and the facility Manager were responsible for updating the therapeutic diet order list in the kitchen but it was "missed" due to being busy with the recent holidays.	D 309		
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	D 358		

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by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

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

Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 6 sampled residents (#11, #10, and #1) related to a medication used to treat high blood pressure (#11), a medication used to treat pain (#10), and a medication used to treat and prevent bone loss (#1).

The findings are:

1. Review of Resident #11's current FL2 dated 05/10/24 revealed:
-Diagnoses included schizoaffective disorder and memory loss.
-Resident #11 was constantly disoriented.

a. Review of Resident #11's physician's orders dated 09/13/24 revealed:
-An order for carvedilol (used to treat high blood pressure) 3.125mg tablet twice daily.
-An order to check blood pressure twice daily before blood pressure medication was given and hold carvedilol for systolic blood pressure less than 110.

Review of Resident #11's electronic medication administration record (eMAR) for January 2025 revealed:
-There was documentation of an order for carvedilol 3.125mg tablet twice daily with meals;

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hold for systolic blood pressure less than 110.
-There was documentation of an order to check blood pressure twice daily before medications are given, hold carvedilol for systolic blood pressure less than 110.

Observation of the medication pass on 01/03/25 at 8:01am revealed:
-The medication aide (MA) was observed to administer carvedilol 3.125mg tablet to Resident #11.
-After the MA administered the carvedilol 3.125mg tablet to Resident #11, the MA checked his blood pressure.

Interview with the MA on 01/03/25 at 8:04am revealed:
-The night shift MA or personal care aide (PCA) usually got the vital signs for the morning shift staff.
-The night shift staff did not get Resident #11's blood pressure during their shift on 01/03/25.
-She administered Resident #11's carvedilol before taking his blood pressure.
-She should have checked his blood pressure before administering the carvedilol.

Telephone interview with the primary care provider (PCP) on 01/03/25 at 3:04pm revealed:
-Anytime a MA did not follow prescribed medication orders, it had the potential to be harmful to the resident.
-For Resident #11, the parameter was to hold his carvedilol if his systolic blood pressure was less than 110.
-The administration of the carvedilol when his systolic blood pressure was less than 110 placed him at high risk for hypotensive episodes that increased his risk for falls.
-Resident #11 had no recent falls that she was

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D 358	Continued From page 31 aware of. Interview with the Administrator on 01/06/25 at 12:59am revealed: -She was not aware a MA was administering a medication prior to taking Resident #11's blood pressure. -She did not know why the MA had not taken Resident #11's blood pressure first before administering his blood pressure medication. -All MAs should be following physician's orders for medication administration including following parameters set to administer or not administer a medication. b. Review of Resident #11's physician's orders dated 09/13/24 revealed: -An order for carvedilol 3.125mg tablet twice daily. -An order to check blood pressure twice daily before blood pressure medication was given and hold carvedilol for systolic blood pressure less than 110. Review of Resident #11's electronic medication administration record (eMAR) for December 2024 revealed: -Resident #11 had a documented blood pressure of 101/72 at 7:00am on 12/08/24. -There was documentation Resident #11 was administered carvedilol 3.125mg tablet at 7:00am on 12/08/24. -Resident #11 had a documented blood pressure of 108/70 at 4:00pm on 12/16/24. -There was documentation Resident #11 was administered carvedilol 3.125mg tablet at 5:00pm on 12/16/24. -Resident #11 had a documented blood pressure of 104/66 at 4:00pm on 12/19/24. -There was documentation Resident #11 was	D 358		

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administered carvedilol 3.125mg tablet at 5:00pm on 12/19/24.
-Resident #11 had a documented blood pressure of 109/81 at 7:00am on 12/22/24.
-There was documentation Resident #11 was administered carvedilol 3.125mg tablet at 7:00am on 12/22/24.

Review of Resident #11's eMAR for January 1-3, 2025, revealed:
-Resident #11 had a documented blood pressure of 99/70 at 7:00am on 01/01/25.
-There was documentation Resident #11 was administered carvedilol 3.125mg tablet at 7:00am on 01/01/25.

Telephone interview with a MA on 01/03/25 at 12:06pm revealed:
-She was familiar with Resident #11 and the medications prescribed to him.
-She was not aware she was supposed to hold his carvedilol if his systolic blood pressure was below 110.
-She administered his carvedilol regardless of what his blood pressure was.

Telephone interview with Resident #11's primary care provider (PCP) on 01/03/25 at 3:04pm revealed:
-Anytime a MA did not follow prescribed medication orders, it had the potential to be harmful to the resident.
-For Resident #11, the parameter was to hold his carvedilol if his systolic blood pressure was less than 110.
-She had not been made aware of his systolic pressures that were less than 110 in December 2024 or January 2025.
-The administration of the carvedilol when his systolic blood pressure was less than 110 placed

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D 358	Continued From page 33 him at high risk for hypotensive episodes that increased his risk for falls. Interview with the Administrator on 01/06/25 at 12:59am revealed all MAs should be following physician's orders for medication administration including following parameters set to administer or not administer a medication. 2. Review of Resident #10's current FL2 dated 10/22/24 revealed: -Diagnoses included chronic pain and diabetes. -Resident #10 was semi-ambulatory. Review of Resident #10's physician's orders revealed an order dated 10/04/24 for diclofenac sodium (used to treat pain and inflammation) 1% gel apply 2 grams topically to the affected area on left knee four times daily. Review of Resident #10's January 2025 eMAR revealed: -There was documentation Resident #10 was administered diclofenac sodium 1% gel to her left knee four times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm on 01/01/25 and 01/02/25. -There was documentation Resident #10 was administered diclofenac sodium 1% gel to her left knee at 8:00am and 12:00pm on 01/03/25. Observation of the medication pass on 01/03/25 at 7:34am revealed: -The MA correctly administered the diclofenac sodium 1% gel to Resident #10's left knee. -Resident #10 asked the MA to administer the diclofenac sodium 1% gel to her right knee as well. -The MA administered the diclofenac sodium 1% gel to Resident #10's right knee.	D 358		

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Interview with the MA on 01/03/25 at 8:04am revealed:
-Resident #10 had chronic pain in both knees.
-Resident #10 requested the medicated gel be placed on her right knee as well as her left.
-She did not realize she could not put the medicated gel on Resident #10's right knee without an order from Resident #10's primary care provider (PCP) since Resident #10 requested it.

Telephone interview with the PCP on 01/03/25 at 3:04pm revealed:
-There was not an order to administer the diclofenac sodium 1% gel to Resident #10's right knee.
-Anytime a MA did not follow medication orders, it had the potential to be harmful to the resident.

Interview with the Administrator on 01/06/25 at 12:59pm revealed:
-The MA should follow the medication administration orders from the PCP.
-The MA should not have administered the diclofenac sodium 1% gel to an area on Resident #10's body that was not specified in the PCP orders.

3. Review of Resident #1's current FL2 dated 08/16/24 revealed:
-Diagnoses included dementia and diabetes.
-There was documentation she used a walker as needed for ambulation.

Review of Resident #1's physician orders dated 06/20/24 revealed an order for alendronate sodium (used to prevent and treat bone loss) 70mg tablet once weekly.

Review of Resident #1's November 2024 eMAR

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revealed:
-There was an order for alendronate sodium 70mg tablet once weekly.
-On the November 2024 eMAR the dates indicated for administration of alendronate sodium were 11/02/24, 11/09/24, 11/16/24, 11/23/24, and 11/30/24.
-There was documentation alendronate sodium was administered on 11/23/24.
-There was no documentation alendronate sodium was administered on 11/02/24, 11/09/24, 11/16/24, and 11/30/24 with a documented reason as "medication not delivered."

Interview with a MA on 01/02/25 at 2:56pm revealed:
-Resident #1's alendronate sodium 70mg tablet was not available to be administered twice in November 2024 when she was working.
-She documented on the eMAR that the medication has not been delivered from the pharmacy.
-She did not know who reviewed the eMARs.
-She only documented on the eMAR and did not tell anyone at the facility the alendronate sodium had not been delivered from the pharmacy.
-She did not call the pharmacy to request the alendronate sodium for Resident #1 be sent to the facility.

Telephone interview with a representative from the facility's contracted pharmacy on 01/06/25 at 9:02am revealed:
-They had an active order for Resident #1 to have alendronate sodium 70mg tablet once a week.
-In October 2024, four tablets were delivered to the facility.
-In November 2024, eight tablets were delivered to the facility.
-In December 2024, five tablets were delivered to

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the facility.
-The alendronate sodium tablets were on cycle fill and sent to the facility monthly.
-The pharmacy had no record of staff from the facility notifying them the alendronate sodium tablets had not been delivered or a request from facility staff to send alendronate sodium tablets for Resident #1.
-There should have been enough alendronate sodium for Resident #1 since she only took it once a week.

Review of the facility's pharmacy delivery sheets dated 10/02/24 revealed four alendronate sodium 70mg tablets were delivered to the facility for Resident #1.

Review of the facility's pharmacy delivery sheets dated 11/04/24 revealed eight alendronate sodium 70mg tablets were delivered to the facility for Resident #1.

Review of the facility's pharmacy delivery sheets dated 12/03/24 revealed five alendronate sodium 70mg tablets were delivered to the facility for Resident #1.

Interview with the Administrator on 01/06/25 at 12:59pm revealed:
-If a medication was not available in the medication cart, the MA should let her or the Facility Manager know so they could look for the medication or call the pharmacy to verify if the medication was delivered.
-If the medication was delivered, they needed to know so it could be located.
-She was not aware there was documentation Resident #1 had not received her alendronate sodium for 4 of 5 weeks in November 2025.
-The medication was available in the facility and

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D 358	Continued From page 37 she was unsure why it had not been administered. -The Resident Care Coordinator (RCC) was responsible for medication cart audits and reviewing the eMAR. -They currently did not have an RCC and no one had completed cart audits since the RCC left about a month ago. The facility failed to follow medication orders for administration of a blood pressure medication by administering the medication before the blood pressure was taken (#11) and administering the medication outside the parameters set by the Primary Care Provider (PCP). The facility's failure was detrimental to the health 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 01/03/25. _____ CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 20TH, 2025.	D 358		
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	D 611		

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D 611	Continued From page 38 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 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:	D 611		

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D 611	Continued From page 39 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 3 of 3 sampled residents (#2, #8, and #9) with diabetes and orders fingerstick blood sugar (FSBS) checks, resulting in sharing of glucometers between residents. The findings are: Review of the CDC guidelines for blood glucose monitoring dated 08/07/24 revealed: -Do not share blood glucose meters. -If you must share blood glucose meters 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 Diabetic and Blood Sugar Policy revealed there was no information on glucometer use. 1. Review of Resident #2's current FL2 dated 05/17/24 revealed diagnoses included legal blindness, type 2 diabetes uncontrolled, and contractures. Review of Resident #2's Primary Care Provider (PCP) order dated 11/13/24 revealed check FSBS daily and record. Review of Resident #2's PCP order dated 12/31/24 revealed start FSBS twice daily.	D 611		

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D 611	Continued From page 40 Observation of two glucometers stored on medication cart A on 01/02/25 at 2:40pm revealed: -There were two glucometers stored in the top left drawer of medication cart A. -Brand A glucometer was stored without a case. -Brand B glucometer was stored in an unlabeled black zippered storage case. -The glucometers were not labeled. Review of the manufacturer's user manual for Brand B glucometer revealed it was intended to be used by a single person and should not be shared. Interview with the medication aide (MA) on 01/02/25 at 2:33pm revealed: -She had "no idea" why the two glucometers stored on medication cart A were not labeled with a resident name. -She used the Brand B glucometer stored on medication cart A to check Resident #2's FSBS. Review of Resident #2's December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS once daily scheduled at 8:00am. -There was documentation Resident #2's FSBS was checked once daily at 8:00am. Review of Resident #2's glucometer history from 12/20 to 12/31 (no year indicated) revealed: -The date was 01/02 (no year indicated) at 3:24pm when the glucometer was powered on 01/02/25 at 3:22pm. -There were 52 FSBS values recorded in history of the glucometer dated 12/20-12/31 (no year indicated).	D 611		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 611	Continued From page 41 -There were 8 FSBS values recorded in the history which matched the FSBS values documented on Resident #2's December 2024 eMAR. -On 12/20 at 7:20am, the FSBS was 174 and the documented FSBS on the eMAR was 174 on 12/20/24 at 8:00am. -On 12/21 at 5:31am, the FSBS was 184 and the documented FSBS on the eMAR was 184 on 12/21/24 at 8:00am. -On 12/22 at 5:29am, the FSBS was 249 and the documented FSBS on the eMAR was 249 on 12/22/24 at 8:00am. -On 12/23 at 8:26am, the FSBS was 319 and the documented FSBS on the eMAR was 319 on 12/23/24 at 8:00am. -On 12/25 at 7:10am, the FSBS was 313 and the documented FSBS on the eMAR was 313 on 12/25/24 at 8:00am. -On 12/29 at 6:49am, the FSBS was 208 and the documented FSBS on the eMAR was 208 on 12/29/24 at 8:00am. -On 12/30 at 10:24am, the FSBS was 299 and the documented FSBS on the eMAR was 299 on 12/30/24 at 8:00am. -On 12/31 at 7:21am, the FSBS was 212 and the documented FSBS on the eMAR was 212 on 12/31/24 at 8:00am. -There were 4 FSBS values documented on Resident #2's December eMAR which were not recorded in the glucometer history. -There were no FSBS readings in Resident #2's glucometer history with a documented value of 319 on 12/24/24 at 8:00am or 134 on 12/28/24 at 8:00am. -On 12/26/24 at 8:00am, the documented FSBS was 250 and corresponded to Resident #8's glucometer history on 12/11 at 1:42am. -On 12/27/24 at 8:00am, the documented FSBS was 226 and corresponded to Resident #8's	D 611		

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glucometer history on 12/12 at 4:22am.

Review of Resident #2's January 2025 eMAR revealed:
-There was an entry for FSBS once daily scheduled at 8:00am.
-There was documentation Resident #2's FSBS was checked once daily at 8:00am.

Review of Resident #2's glucometer history from 01/01 (no year indicated) revealed:
-The date was 01/02 (no year indicated) at 3:24pm when the glucometer was powered on 01/02/25 at 3:22pm.
-There were 2 FSBS values recorded in the history of the glucometer dated 01/01 (no year indicated).
-There were no FSBS values recorded in the history of the glucometer which matched the FSBS values recorded on Resident #2's January 2024 eMAR.
-On 01/02/25 at 8:00am, a documented FSBS was 152 and corresponded to Resident #8's glucometer history on 12/18 at 3:21am.

Refer to the interview with the MA supervisor on 01/03/25 at 11:12am.

Refer to the interview with the facility Manager on 01/03/25 at 8:54am.

Refer to the interview with the Administrator on 01/06/25 at 12:00pm.

2. Review of Resident #9's current FL2 dated 08/12/24 revealed diagnoses included chronic obstructive pulmonary disease, diabetes, hypertension, and long-term insulin use.

Review of Resident #9's Primary Care Provider

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(PCP) order dated 09/13/24 revealed check and record FSBS twice daily before breakfast and before supper.

Interview with the medication aide (MA) on 01/02/25 at 2:33pm revealed she used a glucometer stored on medication cart B to check Resident #9's FSBS.

Observation of glucometers storage in the facility medication carts on 01/02/25 at 2:40pm and 3:08pm revealed:
-There were three glucometers available.
-There was one Brand A glucometer.
-There were two Brand B glucometers.
-The glucometers were not labeled with resident names.

Review of the manufacturer's user manual for Brand B glucometer revealed it was intended to be used by a single person and should not be shared.

Review of Resident #9's December 2024 electronic medication administration record (eMAR) from 12/20/24-12/31/24 revealed:
-There was an entry for FSBS twice daily scheduled at 7:30am and 4:00pm.
-There was documentation Resident #9's FSBS was checked twice daily at 7:30am and 4:00pm.

Review of Resident #2's glucometer history from 12/20 to 12/31 (no year indicated) revealed:
-The date was 01/02 (no year indicated) at 3:24pm when the glucometer was powered on 01/02/25 at 3:22pm.
-There were 52 FSBS values recorded in history of the glucometer dated 12/20-12/31 (no year indicated).
-There were 19 FSBS values recorded in history

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D 611	Continued From page 44 which matched the FSBS values documented on Resident #9's December 2024 electronic medication administration record (eMAR). -On 12/20 at 6:12am, the FSBS was 152 and the documented FSBS on the eMAR was 152 on 12/20/24 at 7:30am. -On 12/20 at 3:42pm, the FSBS was 99 and the documented FSBS on the eMAR was 99 on 12/20/24 at 4:00pm. -On 12/21 at 5:13am, the FSBS was 114 and the documented FSBS on the eMAR was 114 on 12/21/24 at 7:30am. -On 12/21 at 3:29pm, the FSBS was 213 and the documented FSBS on the eMAR was 213 on 12/21/24 at 4:00pm. -On 12/22 at 6:47am, the FSBS was 193 and the documented FSBS on the eMAR was 193 on 12/22/24 at 7:30am. -On 12/22 at 3:04pm, the FSBS was 81 and the documented FSBS on the eMAR was 81 on 12/22/24 at 4:00pm. -On 12/23 at 8:20am, the FSBS was 219 and the documented FSBS on the eMAR was 219 on 12/23/24 at 7:30am. -On 12/23 at 3:51pm, the FSBS was 328 and the documented FSBS on the eMAR was 328 on 12/23/24 at 4:00pm. -On 12/24 at 4:49am, the FSBS was 103 and the documented FSBS on the eMAR was 103 on 12/24/24 at 7:30am. -On 12/24 at 3:57pm, the FSBS was 244 and the documented FSBS on the eMAR was 244 on 12/24/24 at 4:00pm. -On 12/25 at 7:37am, the FSBS was 159 and the documented FSBS on the eMAR was 159 on 12/25/24 at 7:30am. -On 12/25 at 3:26pm, the FSBS was 222 and the documented FSBS on the eMAR was 222 on 12/25/24 at 4:00pm. -On 12/28 at 7:12am, the FSBS was 119 and the	D 611		

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documented FSBS on the eMAR was 119 on 12/28/24 at 7:30am.
-On 12/28 at 3:33pm, the FSBS was 310 and the documented FSBS on the eMAR was 310 on 12/28/24 at 4:00pm.
-On 12/29 at 3:41pm, the FSBS was 161 and the documented FSBS on the eMAR was 161 on 12/29/24 at 4:00pm.
-On 12/30 at 5:15am, the FSBS was 184 and the documented FSBS on the eMAR was 184 on 12/30/24 at 7:30am.
-On 12/30 at 3:44pm, the FSBS was 113 and the documented FSBS on the eMAR was 113 on 12/30/24 at 4:00pm.
-On 12/31 at 3:20pm, the FSBS was 149 and the documented FSBS on the eMAR was 149 on 12/31/24 at 4:00pm.
-There were 6 FSBS values documented on Resident #9's December eMAR which were not recorded in the glucometer history.
-There were no FSBS readings in Resident #2's glucometer history with a documented value of 128 on 12/29/24 at 7:30am or 121 on 12/31/24 at 7:30am.
-On 12/26/24 at 7:30am, the documented FSBS was 127 and corresponded to Resident #8's glucometer history on 12/11 at 1:44am.
-On 12/26/24 at 4:00pm, the documented FSBS was 143 and corresponded to Resident #8's glucometer history on 12/11/ at 12:07pm.
-On 12/27/24 at 7:30am, the documented FSBS was 147 and corresponded to Resident #8's glucometer history on 12/12 at 3:17am.
-On 12/27/24 at 4:00pm, the documented FSBS was 79 and corresponded to Resident #8's glucometer history on 12/12 at 11:29am.

Review of Resident #2's glucometer history for 01/01 (no year indicated) revealed:
-The date was 01/02 (no year indicated) at

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3:24pm when the glucometer was powered on 01/02/25 at 3:22pm.
-There were 2 FSBS values recorded in history of the glucometer dated 01/01 (no year indicated).
-There was 1 FSBS value recorded in history which matched the FSBS values documented on Resident #9's January 2025 eMAR.
-On 01/01 at 7:03am, the FSBS was 171 and the documented FSBS on the eMAR was 171 on 01/01/25 at 7:30am.
-On 01/01/25 at 4:00pm, the documented FSBS was 108 and corresponded to Resident #8's glucometer history on 12/17 at 12:14pm.

Refer to the interview with the MA supervisor on 01/03/25 at 11:12am.

Refer to the interview with the facility Manager on 01/03/25 at 8:54am.

Refer to the interview with the Administrator on 01/06/25 at 12:00pm.
3. Review of Resident #8's current FL2 dated 02/27/24 revealed diagnoses included diabetes mellitus type 2, long term use insulin, hemiplegia, osteoarthritis, and major depressive disorder.

Review of Resident #8's physician's orders dated 11/05/24 revealed there was an order to check finger stick blood sugars (FSBS) twice daily before meals at 8:00am and 5:00pm and notify the provider if the value was less than 70 or greater than 350.

Observation of a glucometer stored on medication cart B on 01/02/25 at 3:29pm revealed:
-There was one glucometer stored in the top drawer of medication cart B.
-There was a Brand B glucometer stored in an

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unlabeled black zippered storage case.
-The Brand B glucometer was not labeled.

Review of the manufacturer's user manual for the Brand B glucometer revealed it was intended to be used by a single person and not be shared.

Interview with a medication aide (MA) on 01/02/25 at 3:29pm revealed:
-She used the Brand B glucometer on medication cart B to check Resident #8's FSBS.
-She did not know why Resident #8's glucometer was not labeled.

Review of Resident #8's electronic medication administration records (eMARs) from 12/20/24-12/31/24 revealed:
-There was an entry for FSBS twice daily at 8:00am and 5:00pm.
-There was documentation Resident #8's FSBS was checked twice daily at 8:00am and 5:00pm.

Review of Resident #8's Brand B glucometer history from medication cart B compared to the eMARs from 12/20/24-12/31/24 revealed:
-The date was 12/18 (no year indicated) at 3:21am when the glucometer was powered on 01/02/25 at 3:29pm.
-There were 15 FSBS values recorded in the history of the glucometer dated 12/11-12/12 with no year indicated.
-There were 3 FSBS values recorded in the history on 12/11 and 12/12 that matched the FSBS values on Resident #8's eMARs on 12/26/24 at 8:00am, 12/26/24 at 5:00pm, and on 12/27/24 at 8:00am.
-There were 12 FSBS values documented on Resident #8's eMAR from 12/20/24-12/31/24 that were not recorded in Resident #8's glucometer history.

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D 611	Continued From page 48 -On 12/11 at 1:42am, there was a FSBS value of 250 that corresponded to a documented value on Resident #2's eMAR on 12/26/24 at 8:00am. -On 12/11 at 1:44am, there was a FSBS value of 127 that corresponded to a documented value on Resident #9's eMAR on 12/26/24 at 7:30am. -On 12/11 at 12:07pm, there was a FSBS value of 143 that corresponded to a documented value on Resident #9's eMAR on 12/26/24 at 4:00pm. -On 12/12 at 4:22am, there was a FSBS value of 226 that corresponded to a documented value on Resident #2's eMAR on 12/27/24 at 8:00am. -On 12/12 at 3:17am, there was a FSBS value of 147 that corresponded to a documented value on Resident #9's eMAR on 12/27/24 at 7:30am. -On 12/12 at 11:29am, there was a FSBS value of 79 that corresponded to a documented value on Resident #9's eMAR on 12/27/24 at 4:00pm. Review of Resident #8's eMARs from 01/01/25-01/02/25 revealed: -There was an entry for FSBS twice daily at 8:00am and 5:00pm. -There was documentation Resident #8's FSBS was checked twice daily at 8:00am and 5:00pm. Review of Resident #8's Brand B glucometer history from medication cart B compared to the eMARs from 01/01/25-01/02/25 revealed: -The date was 12/18 (no year indicated) at 3:21am when the glucometer was powered on 01/02/25 at 3:29pm. -There were 3 FSBS values recorded in the history of the glucometer dated 12/17 and 12/18 with no year indicated. -There was one FSBS value of 226 recorded in the history on 12/17 at 12:33pm that matched the FSBS values on Resident #8's eMARs on 01/01/25 at 5:00pm. -There were no FSBS readings in Resident #8's	D 611		

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glucometer history with a documented FSBS value of 131 on 01/01/24 at 8:00am or 139 on 01/02/24 at 8:00am.
-On 12/17 at 12:14pm, there was a FSBS value of 108 that corresponded to a documented value on Resident #9's eMAR on 01/01/25 at 4:00pm.
-On 12/18 at 3:21am, there was a FSBS value of 152 that corresponded to a documented value on Resident #2's eMAR on 01/02/25 at 8:00am.

Telephone interview with a customer service technician from Brand B's glucometer manufacturer on 01/03/25 at 10:25am revealed Brand B glucometers were intended for single use only and not meant to be shared.

Refer to the interview with the MA supervisor on 01/03/25 at 11:12am.

Refer to the interview with the facility Manager on 01/03/25 at 8:54am.

Refere to the interview with the Administrator on 01/06/25 at 12:00pm.

_____

Interview with a medication aide (MA) supervisor on 01/03/25 at 11:12am revealed:
-She knew some residents with orders for fingerstick blood sugars (FSBS) did not have a glucometer.
-Glucometer sharing between residents was not allowed.
-She wiped the glucometer with an alcohol pad after checking a FSBS before using the same glucometer to check another resident's FSBS.
-The former MA supervisor trained her and told her it was okay to share the glucometers for residents if the glucometer was cleaned off with an alcohol pad in between residents.
-She informed the facility Manager there were

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D 611	Continued From page 50 only 3 glucometers available on the medication carts to check 5 residents blood sugars when the Manager started working at the facility about 4 months ago. -Each resident with orders for FSBS did not have a glucometer because "everything was hectic" at the facility when the Manager started. Interview with the facility Manager on 01/03/25 at 8:54am revealed: -He was not aware the MAs were sharing glucometers between residents because there were only 3 glucometers available. -He did not know that each resident with orders for FSBS did not have a glucometer available for use. -Glucometer sharing was not allowed. -The former Resident Care Coordinator (RCC) was responsible for medication cart audits including checking to make sure each resident with orders for FSBS had a glucometer and the glucometer was labeled. Interview with the Administrator on 01/06/25 at 12:00pm revealed: -She did not know the medication aides (MAs) were sharing glucometers between residents. -She had not been checking the histories of the glucometers for sharing. -She assumed the MAs would not share glucometers, because all the MAs had received infection control training specifically related to glucometer use. -There was no reason for an MA to share a glucometer. -The glucometers were provided free of charge from the facility's contracted pharmacy. _____ The facility failed to implement infection control procedures consistent with the federal Center for	D 611		

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D 611	Continued From page 51 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, #8, and #9 and two other residents with FSBS checked and no other glucometers available. 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 January 2, 2025 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 20, 2025.	D 611		