

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/08/2021
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
(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
{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on October 7-8, 2021.	{C 000}		
{C 246}	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to refer 2 of 2 sampled diabetic residents (#1 and #2), who needed their toenails trimmed (#1, #2) and a large callus on the bottom of her foot debrided (#2) to a podiatrist. The findings are: 1. Review of Resident #1's current FL-2 dated 04/15/21 revealed diagnoses included schizophrenia, chronic obstructive pulmonary disease (COPD), and history of cerebrovascular accident. Observation of Resident #1's toenails on 10/07/21 at 9:36am revealed: -Resident #1 was walking around on the inside and outside of the facility without shoes. -The first toenail on her left foot was three-fourths to one inch long; it was jagged and had grime under the nail. -The first toenail on her right foot was	{C 246}		

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

TITLE

(X6) DATE

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{C 246}	Continued From page 1 three-fourths to one inch long; it was jagged and had grime under the nail. -The toenails on all other toes on both the left and right feet were one-fourth to three-fourths an inch long; they were jagged and dirty. Interview with Resident #1 on 10/07/21 at 9:38am revealed: -She had not seen a foot doctor (podiatrist) in a long time. -Her toenails looked "awful." -Her toenails needed to be cut because it hurt her to wear shoes. -No one had cut her toenails since she had seen the podiatrist (she did not recall when this was). -She told the nurse her toenails needed to be cut last week; she did not know who the nurse was. Interview with the medication aide (MA) on 10/07/21 at 9:40am revealed: -She helped Resident #1 with a shower on 10/06/21 and when she washed the resident's feet, she noticed how long the resident's toenails were. -She did not call anyone about the resident's toenails because she knew the podiatrist was coming to the facility this month. -The podiatrist came to the facility every other month. -She felt sure Resident #1 was seen the last time the podiatrist was at the facility unless she had refused. Telephone interview with an assistant at the facility's contracted podiatry services office on 10/07/21 at 5:06pm revealed: -Resident #1 was seen on 02/04/21. -The podiatrist scheduled diabetic residents to be seen every 90-days, however when the podiatrist was at the facility in May 2021, Resident #1	{C 246}		

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{C 246}	Continued From page 2 refused podiatry services. Review of Resident #1's Podiatry Visit Summary dated 02/04/21 revealed: -Resident #1 was high risk and was seen for foot evaluation and management. -Resident #1 complained of her toenails being elongated and painful. -Resident #1's toenails were thick, elongated, crumbly, discolored with subungual debris. -Debridement of all 10 toenails was completed on Resident #1's feet. -Discussed with Resident #1 the importance of proper diabetic foot care and the importance of maintaining adequate blood sugar levels. -She explained the possible risks and complications with diabetics and their feet. -She recommended Resident #1 to examine her feet daily, have qualified specialist care for her feet and toenails, and wear socks and shoes at all times. -The resident would be seen again by the podiatrist. -A diabetic foot handout was reviewed and dispensed to the resident. -The resident was instructed to contact the Podiatrist with any problems and/or concerns. Review of Resident #1's Licensed Health Professional Support (LHPS) review dated 08/09/21 revealed: -Resident #1 was seen for the tasks of collecting and sampling finger stick blood sugar (FSBS). -Resident #1 had a callus to the left lateral side of the foot, her heels were cracked, and her toenails needed to be trimmed. -Recommendations included making sure Resident #1's toenails were trimmed, and the resident was routinely seen by podiatry for diabetic foot care.	{C 246}		

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{C 246}	Continued From page 3 Telephone interview with the LHPS nurse on 10/08/21 at 11:30am revealed: -Resident #1 was a diabetic and needed to be seen on a regular basis by a podiatrist. -Resident #1's toenails needed to be trimmed, as well as overall diabetic foot care. Telephone interview with Resident #1's Primary Care Provider (PCP) on 10/08/21 at 11:55am revealed a podiatrist was "lined up" with the facility and deferred all questions to the podiatrist. Interview with the Assistant Administrator on 10/08/21 at 2:03pm revealed whoever was working and saw Resident #1's toenails needed to be trimmed should have contacted the Podiatrist. Refer to the interview with the Assistant Administrator on 10/07/21 at 10:17am. Refer to the telephone interview with an assistant at the facility's contracted podiatry services office on 10/07/21 at 5:06pm. Refer to the telephone interview with the facility's contracted Podiatrist on 10/07/21 at 5:10pm. Refer to the telephone interview with the Supervisor-in-Charge (SIC) on 10/08/21 at 10:45am. Refer to the telephone interview with the LHPS nurse on 10/08/21 at 11:30am. Refer to the interview with the Assistant Administrator on 10/08/21 at 2:03pm. Refer to the interview with the Administrator on	{C 246}		

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{C 246}	Continued From page 4 10/08/21 at 1:11pm. 2. Review of Resident #2's current FL-2 dated 04/15/21 revealed diagnoses included type 2 diabetes, schizophrenia, hypertension, chronic obstructive pulmonary disease (COPD), and arthritis. Observation of Resident #2's feet on 10/07/21 at 11:44am revealed: -The first toenail on her left foot was three-fourths to one inch long. -The second toenail on her left foot was three-fourths to one inch long and was beginning to turn downward. -The first toenail on her right foot was broken and jagged. -The second toenail on her right foot was a one-fourth inch long. -The toenails on all other toes on both the left and right feet were one-fourth to three-fourths an inch long. -There was a large callus (build-up of thickened skin) that was black in color and was raised ½ inch off the bottom of her left foot; the callus covered the entire bottom of the first toe. Interview with Resident #2 on 10/07/21 at 11:37am revealed: -Her toenails needed to be trimmed. -She had not seen a foot doctor (podiatrist) in a long time. -She needed to see the podiatrist for "this thing" (callus) worse than she needed her toenails cut. -The callus used to hurt worse than it did now. Telephone interview with a medication aide (MA) on 10/07/21 at 3:27pm revealed she had not noticed Resident #2's toenails because she was independent with her personal care.	{C 246}		

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{C 246}	Continued From page 5 Telephone interview with an assistant at the facility's contracted podiatry services office on 10/07/21 at 5:06pm revealed: -Resident #2 was seen on 02/04/21. -The podiatrist scheduled diabetic residents to be seen every 90-days, however when the podiatrist was at the facility in May 2021, Resident #2 refused podiatry services. Review of Resident #2's Podiatry Visit Summary dated 02/04/21 revealed: -Resident #2 was high risk and was seen for foot evaluation and management. -Resident #2 complained of her toenails being elongated and painful. -Resident #2 complained of a painful callus of the left foot that caused moderate pain when walking. -Resident #2's toenails were thick, elongated, crumbly, discolored with subungual debris. -Debridement of all 10 toenails was completed on Resident #2's feet. -Debridement of hyperkeratotic lesions (callus) was performed. -She discussed with Resident #2 the importance of proper diabetic foot care and the importance of maintaining adequate blood sugar levels. -She explained the possible risks and complications with diabetics and their feet. -She recommended Resident #2 to examine her feet daily, have qualified specialist care for her feet and toenails, and wear socks and shoes at all times. -The resident would be seen again by the podiatrist. -A diabetic foot handout was reviewed and dispensed to the resident. -The resident was instructed to contact the Podiatrist with any problems and/or concerns.	{C 246}		

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{C 246}	Continued From page 6 Review of Resident #2's Licensed Health Professional Support (LHPS) review dated 08/09/21 revealed: -Resident #2 was seen for the tasks of collecting and sampling finger stick blood sugar (FSBS). -Resident #2 had a large callus under her left great toe, and her toenails needed to be trimmed. -Recommendation for Resident #2's was to make sure her toenails were trimmed. Telephone interview with the LHPS nurse on 10/08/21 at 11:30am revealed: -Resident #2 was a diabetic and needed to be seen on a regular basis by a Podiatrist. -Resident #2's toenails needed to be trimmed, as well as overall diabetic foot care. Telephone interview with Resident #2's Primary Care Provider (PCP) on 10/08/21 at 11:55am revealed a podiatrist was "lined up" with the facility and deferred all questions to the podiatrist. Telephone interview with Resident #2's podiatrist on 10/07/21 at 5:10pm revealed if Resident #2's callus was not debrided it would cause an infection. Interview with the Assistant Administrator on 10/08/21 at 2:03pm revealed diabetic residents should be seen by the podiatrist. Refer to the interview with the Assistant Administrator on 10/07/21 at 10:17am. Refer to the telephone interview with an assistant at the facility's contracted podiatry services office on 10/07/21 at 5:06pm. Refer to the telephone interview with the facility's	{C 246}		

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{C 246}	Continued From page 7 contracted podiatrist on 10/07/21 at 5:10pm. Refer to the telephone interview with the Supervisor-in-Charge (SIC) on 10/08/21 at 10:45am. Refer to the telephone interview with the LHPS nurse on 10/08/21 at 11:30am. Refer to the interview with the Assistant Administrator on 10/08/21 at 2:03pm. Refer to the interview with the Administrator on 10/08/21 at 1:11pm. Interview with the Assistant Administrator on 10/07/21 at 10:17am revealed: -The podiatrist was at the facility once every three months. -The podiatrist called to notify staff when she was going to be at the facility. -She was not sure when the podiatrist was last at the facility. -The Supervisor-in-Charge (SIC) was responsible for scheduling the podiatry visits. Telephone interview with an assistant at the facility's contracted podiatry services office on 10/07/21 at 5:06pm revealed: -Diabetic residents typically would be seen every 3-months for diabetic foot care. -The podiatrist was at the facility in May 2021. -The podiatrist was scheduled to see residents at the facility on 08/28/21 and the Administrator canceled because the facility was not prepared for the visit. -The facility had to have proper paperwork copied and available the day of the visit and she was told the paperwork was not ready. -She rescheduled the visit for 09/14/21, but when	{C 246}		

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{C 246}	Continued From page 8 she called to confirm the visit, no one returned her call. -She had left a message with staff (she did not document who she had spoken to) and had left a voicemail for the Administrator. -She had documented calls on 09/07/21, 09/08/21, 09/10/21, and 09/14/21 to confirm the appointment on 09/14/21, but did not receive any return calls for confirmation. Telephone interview with the facility's contracted podiatrist on 10/07/21 at 5:10pm revealed: -She saw residents at the facility every 3-months. -The staff were responsible for bringing the residents into the room she was set up in to see residents. -She could not make residents see her; the residents had the right to refuse care. -She thought poor pedal care was an issue with all the residents at the facility. -The residents were not washing their feet, applying lotion and overall proper foot care was an issue. -She had an appointment to see the residents at the facility in August 2021 and the facility staff canceled. -Her office staff had made multiple attempts to schedule her visit to the facility. -She expected the facility staff to call and reschedule her visit to the facility. Telephone interview with the SIC on 10/08/21 at 10:45am revealed: -The podiatrist was at the facility in February 2021 and automatically saw the residents every 90-days. -Some of the residents refused to be seen in May 2021. -She did not know why the podiatrist did not visit the facility in August 2021.	{C 246}		

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{C 246}	Continued From page 9 -She had called the podiatrist office today , 10/08/21, to reschedule the visit. -She did not know why the staff at the podiatrist's office would say they did not have everything ready because they always had everything ready. -She did not know who the staff at the podiatrist office had spoken to, but she thought the Administrator would have called the podiatrist office back had he received a voicemail. Telephone interview with the LHPS nurse on 10/08/21 at 11:30am revealed: -Diabetic residents were at increased risk of developing foot problems and because diabetics may develop neuropathy (loss of sensation) they may not recognize problems. -Unmanaged foot care for diabetic residents puts the residents at risk of infection which could lead to loss of toes. Interview with the Assistant Administrator on 10/08/21 at 2:03pm revealed: -She had heard the SIC's call to the podiatrist office. -She did not know what happened to reschedule the appointment, but "someone dropped the ball" and she did not know who. Interview with the Administrator on 10/08/21 at 1:11pm revealed he had not received any calls to reschedule the August 2021 Podiatry visit. The facility failed to ensure 2 of 2 residents who had a diagnosis of diabetes received foot and nail care by a podiatrist, which resulted in Resident #1 having long, jagged toenails that were painful to wear shoes; and Resident #2, who also had long jagged toenails, and a large callus on the bottom of her foot, and put the residents at risk for infection, foot ulcers, gangrene and amputation.	{C 246}		

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{C 246}	Continued From page 10 This failure was detrimental to the residents' health, safety, and welfare and constitutes an Unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/02/19 for this violation.	{C 246}		
{C 330}	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record review the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #1) related to a medication used to treat type II diabetes mellitus. The findings are: Review of Resident #1's current FL-2 dated 08/02/21 revealed: -Diagnoses included hypertension, chronic	{C 330}		

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{C 330}	Continued From page 11 obstructive pulmonary disease (COPD), hypothyroidism, and history of cerebrovascular accident. -There was an order for Levemir inject 20 units two times a day. (Levemir is a long-acting insulin that is used to control high blood sugar). -There was an order to check finger stick blood sugar (FSBS) twice daily. Review of Resident #1's August 2021, September 2021, and October 2021 medication administration record (MAR) revealed: -There was an entry for Levemir inject 20 units subcutaneously twice daily scheduled at 8:00am and 5:00pm. -There were no orders for parameters. -There was documentation Resident #1's Levemir was administered twice daily from 08/01/21-08/31/21, 09/01/21-09/30/21 and 10/01/21-10/07/21. -There were no exceptions documented between 08/01/21-10/07/21. Review of Resident #1's FSBS results log revealed: -From 09/01/21-09/30/21, Resident #1's FSBS were documented ranging from 52-310. -On 09/03/21 at 7:00am, Resident #1's FSBS was documented as 52 and at 4:00pm was documented as 271. -On 09/10/21 at 7:00am, Resident #1's FSBS was documented as 54 and at 4:00pm was documented as 200. -From 10/01/21-10/08/21, Resident #1's FSBS were documented ranging from 74-272. -On 10/04/21 at 7:00am, Resident #1's FSBS was documented as 74 and at 4:00pm was documented as 210. -On 10/07/21 at 7:00am, Resident #1's FSBS was documented as 142.	{C 330}		

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{C 330}	Continued From page 12 Observation of Resident #1's medication on hand on 10/07/21 at 10:30am revealed: -There was a box labeled Levemir pens with an order to inject 20 units twice daily. -The dispense date on the box of Levemir pens was 10/06/21; five 15mL pens were dispensed in the box. -A Levemir 3ml pen contains 300 units of insulin. -There was one Levemir pen that was dated as opened on 10/04/21 with approximately 240 units of 300 units remaining in the pen. -There were six additional Levemir pens that had not been opened. Review of Resident #1's pharmacy dispensing record for Levemir revealed one box of Levemir 100 units/ml with five pens per box was dispensed on 08/31/21 and 10/06/21; each dispensing was for a 37-day supply based on 20 units twice daily. Based on observation, interviews, and record reviews, five Levemir pens were dispensed on 08/31/21 which was a 37-day supply and would have been used by 10/07/21 and on 10/07/21, two of the five Levemir pens were available to be administered, and therefore Resident #1's Levemir could not have been administered twice a day as ordered. Interview with Resident #1 on 10/07/21 at 11:54am revealed: -She was administered insulin only when she needed it. -She got an injection only if her "sugar" (FSBS) results were high; she did not know what her FSBS needed to be, to be administered her insulin; she did not get an insulin injection twice every day.	{C 330}		

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NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
(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
{C 330}	Continued From page 13 -She did not receive an insulin injection today, 10/07/21, because her FSBS was too low. -She did not feel good when her FSBS was too high or too low. Interview with the medication aide (MA) on 10/08/21 at 10:50am revealed: -If Resident #1's FSBS was high (a FSBS above 200), she would administer 20 units of Levemir. -Resident #1 did not receive insulin on 10/07/21 at breakfast but did receive insulin at dinner because the resident's FSBS was 512. -Resident #1 did not have parameters for insulin administration but needed to have parameters. -If Resident #1's FSBS was low she gave her orange juice to drink. Second interview with the MA on 10/08/21 at 12:11pm revealed she only administered Resident #1's Levemir insulin if the resident's FSBS was high, "over 180." Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/07/21 at 4:02pm revealed: -Levemir was used to lower blood glucose levels. -Possible outcomes of Resident #1 not receiving Levemir as ordered could be hyperglycemia; long-term hyperglycemia could cause vision problems, cardiovascular disease, kidney, and other organ damage. Telephone interview with Resident #1's primary care provider (PCP) on 10/08/21 at 11:55am revealed: -She expected the MA to follow Resident #1's Levemir order of 20 units twice daily. -Resident #1's blood glucose A1C was 7.0 in April 2021 or June 2021 (the hemoglobin A1C test tells you your average level of blood sugar over the	{C 330}		

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{C 330}	Continued From page 14 past 2 to 3 months) (according to the American Diabetic Association a HbgA1C value less than 7.0 is a goal for diabetic residents with the normal range for HbgA1C being 4 to 5.9). -Resident #1's blood glucose A1C on 09/29/21 was 8.2 -She had been able to get Resident #1's A1C down to 7.0 and now Resident #1's A1C was back up. -She was concerned Resident #1's Levemir had not been administered as ordered. -Resident #1's finger stick blood sugar (FSBS) would not be as high as it had been documented and would not be fluctuating between hypoglycemia and hyperglycemia if the resident had been administered Levemir as ordered. -There were a lot of negative outcomes to Resident #1 having episodes of hypoglycemia and hyperglycemia including diabetic retinopathy and organ damage. -She expected the MAs to follow the regimen she had ordered. Interview with the Assistant Administrator on 10/08/21 at 2:03pm revealed: -The Assistant Administrator questioned the MA about Resident #1's Levemir administration, and the MA confirmed she did not administer Resident #1's Levemir if the resident's FSBS was low. -She expected the MAs to administer medication as ordered. The facility failed to administer Resident #1's Levemir insulin as ordered which resulted in the resident having episodes of hypoglycemia and hyperglycemia and placed the resident at risk for organ damage. This failure was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation.	{C 330}		

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{C 330}	Continued From page 15	{C 330}		
C 341	The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/08/21 for this violation. 10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the documentation on the Medication Administration Record (MAR) included the initials of the Medication Aide (MA) who administered the medication for 3 of 3 sampled residents (#1, #2, and #3). The findings are: Interviews with three residents on 10/07/21 between 8:05am-9:00am revealed: -The night staff had administered medication today, 10/07/21, and every other day this week too. -The night staff administered medications every morning she was working.	C 341		

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C 341	Continued From page 16 - "Whoever was working administered medications." Review of three residents Medication Administration Records (MAR) for August 2021-October 2021 revealed: - The named staff member's initials were not documented as administering medications. - The day shift Medication Aide (MA) had documented administering medications. Telephone interview with the night staff on 10/07/21 at 3:27pm revealed: - She had not documented administering the medications on the MAR because she was not the staff who "popped" the medication. - The day shift MA popped the medication into cups labeled with the residents' names. - She only administered the cups of medications when the day shift MA was running late. - She usually administered medications 1-2 times per week. - She had administered medications every day this week. - She had been working at the facility for "about five months." - She was still training to be a MA, so she did not think she was supposed to sign the MAR. Interview with the day shift MA on 10/08/21 at 11:01am revealed: - She documented all medications that were administered because she was the one who punched the medications into the labeled cups. - The night shift staff "sometimes" administered the medications, but only if she was running late. - She was running late yesterday, 10/07/21, so the night shift staff had administered the medication. - She documented on the MAR as she punched the medications into the cups labeled for each	C 341			

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C 341	Continued From page 17 resident. Interview with the Assistant Administrator on 10/07/21 at 2:04pm revealed: -The day shift MA was responsible for administering medications. -She did not know the night shift staff had been administering the morning medications. -If the night shift staff administered the morning medications then she should have been the one to sign the MAR when the medication was administered. -She did not know the medication was being pre-poured into cups labeled with the residents' names. -Whoever administered the resident's medications should document the medication administration on the resident's MAR.	C 341		
{C 342}	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and	{C 342}		

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{C 342}	Continued From page 18 (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 04/15/21 revealed Diagnoses included tardive dyskinesia, depression, schizophrenia, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism, and a history of a cerebrovascular accident. a. Review of Resident #1's physician's orders dated 08/16/21 revealed there was an order for Levemir Flextouch inject 20units two times a day. (Levemir is a long-acting insulin that is used to control high blood sugar). Review of Resident #1's August 2021 medication administration record (MAR) revealed: -There was an entry for Levemir Flextouch inject 20 units subcutaneously twice daily scheduled at 8:00am and 5:00pm. -There were no parameters for Resident #1's Levemir injections. -There was documentation Resident #1's Levemir was administered twice daily from 08/01/21-08/31/21. -There were no exceptions documented.	{C 342}		

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{C 342}	Continued From page 19 Review of Resident #1's September 2021 MAR revealed: There was an entry for Levemir Flextouch inject 20 units subcutaneously twice daily scheduled at 8:00am and 5:00pm. -There was documentation Resident #1's Levemir was administered twice daily from 09/01/21-09/30/21. -There were no exceptions documented. Review of Resident #1's October 2021 MAR revealed: There was an entry for Levemir Flextouch inject 20 units subcutaneously twice daily scheduled at 8:00am and 5:00pm. -There was documentation Resident #1's Levemir was administered twice daily from 10/01/21-10/06/21 and at 8:00am on 10/07/21. -There were no exceptions documented. Observation of Resident #1's medication on hand on 10/07/21 at 10:30am revealed: -There was a box labeled Levemir Flextouch pens with an order to inject 20 units twice daily. -The dispense date on the box of Levemir pens was 10/06/21; five 15ml pens were dispensed in the box. -A Levemir 3ml pen contains 300 units of insulin. -There was one Levemir pen that was dated as opened on 10/04/21 with approximately 240 units of 300 units remaining in the pen. -There were six additional Levemir pens that had not been opened. Review of Resident #1's pharmacy dispensing record for Levemir revealed one box of Levemir Flextouch pens with five pens per box was dispensed on 08/31/21 and 10/06/21; each dispensing was for a 37-day supply based on 20 units twice daily.	{C 342}			

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{C 342}	Continued From page 20 Interview with Resident #1 on 10/07/21 at 11:54am revealed: -She did not get an insulin injection twice every day. -She did not receive an insulin injection today, 10/07/21, because her FSBS was too low. Interview with the medication aide (MA) on 10/08/21 at 10:50am revealed: -Resident #1 was not administered Levemir twice daily every day, it depended on the residents FSBS. -She documented Levemir had been administered twice daily every day because she followed suit of what was being done when she started to work at the facility. -She should have documented an exception on the back of the MAR when she did not administer Resident #1's Levemir. Interview with the Assistant Administrator on 10/07/21 at 2:04pm revealed: -She expected the MA who administered medication to document on the MAR. -If a medication was not administered the MA should not document as if the medication was administered, but would document an exception on the back of the MAR. b. Review of Resident #1's physician's orders dated 08/16/21 revealed there was an order for Guaifenesin 100mg/5ml liquid, take two teaspoonfuls every 4-6 hours as needed for coughing. Review of Resident #1's September 2021 medication administration record (MAR) revealed: -There was an entry for Guaifenesin 100mg/5ml liquid, take two teaspoonfuls every 4-6 hours as	{C 342}		

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{C 342}	Continued From page 21 needed for coughing. -There was no documentation Guaifenesin was administered from 09/22/21-09/30/21. Review of Resident #1's October 2021 MAR revealed: -There was an entry for Guaifenesin 100mg/5ml liquid, take two teaspoonfuls every 4-6 hours as needed for coughing. -There was no documentation Guaifenesin was administered from 10/01/21-10/07/21. Observation of Resident #1's medication on hand on 10/07/21 at 10:30am revealed: -There was a bottle of Guaifenesin 100mg/5ml (240ml) liquid dispensed on 09/22/21. -The bottle had less than 100ml of Guaifenesin remaining in the bottle. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 10/07/21 at 4:02pm revealed: -Resident #1's Guaifenesin cough syrup had been dispensed on 09/22/21. -The bottle contained 240ml of cough syrup which would have been 24 doses. Interview with Resident #1 on 10/07/21 at 11:54am revealed: -She was administered cough syrup every morning. -Sometimes the medication aide (MA) gave her cough syrup during the day too. -The MA gave her cough medication today, 10/07/21. Telephone interview with the night shift MA on 10/07/21 at 3:27pm revealed: -She administered the resident's pills before she left the facility today, 10/07/21.	{C 342}		

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{C 342}	Continued From page 22 -Resident #1 was not administered cough medicine today, 10/07/21. -She had never administered Resident #1 cough medicine. -She did not know why Resident #1 would say she had been administered cough medicine today, 10/07/21. Interview with the day shift MA on 10/08/21 at 11:10am revealed: -She did not administer Resident #1's cough syrup today. -She had not administered Resident #1's cough syrup since the medication was dispensed on 09/22/21. -She did not know why there was over one-half of the liquid missing from the cough syrup bottle. Interview with the Assistant Administrator on 10/07/21 at 2:04pm revealed she expected the MA who administered medication to document on the MAR.	{C 342}		
{C 367}	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure records of the receipt and administration of controlled	{C 367}		

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{C 367}	Continued From page 23 substances were maintained, accurate, and reconciled for 1 of 1 sampled resident (Resident #1) with an order for a medication used to treat diarrhea and an anti-anxiety medication. The findings are: Review of Resident #1's current FL-2 dated 04/15/21 revealed: -Diagnoses included tardive dyskinesia, depression, schizophrenia, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism, and a history of a cerebrovascular accident. a. Review of Resident #1's physician's orders dated 08/16/21 revealed there was an order for Lorazepam 1mg take one tablet twice daily as needed or increased agitation and anxiety. Observation of Resident #1's medications on hand on 10/07/21 at 10:32am revealed: -There was a medication punch card for Lorazepam 1mg dispensed on 08/16/21 for 35 tablets. -There were thirty-one tablets of Lorazepam 1mg available to be administered; four tablets had been punched from the medication card. Review of Resident #1's August 2021, September 2021, and October 2021 medication administration record (MAR) revealed: -There was an entry for Lorazepam 1mg, take one tablet twice daily as needed for anxiety. -There was no documentation Lorazepam 1mg was administered between 08/01/21-10/07/21. Review of Resident #1's control substance count sheets (CSCS) revealed: -There was a CSCS log with a handwritten note	{C 367}		

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{C 367}	Continued From page 24 for Resident #1's Lorazepam with no date with the number 60 written in at the top of the form and the directions to take 1 tablet twice daily as needed for increased agitation/ anxiety. -There was no documentation Lorazepam was administered. Interview with the medication aide (MA) on 10/07/21 at 10:32am revealed: -Lorazepam should be documented on the back of the MAR and the CSCS when administered. -She did not know why Resident #1's Lorazepam had not been documented as administered. -She had not administered Resident #1's Lorazepam in "months." Interview with the Assistant Administrator on 10/08/21 at 2:03pm revealed: -Administration of Resident #1's Lorazepam should be documented on the MAR and the CSCS. -She expected the MAs to document the administration of controlled medication. b. Review of Resident #1's physician's orders dated 08/16/21 revealed there was an order for Diphenoxylate HCL/Atropine to take two tablets four times daily for two days as needed for diarrhea. Review of Resident #1's August 2021, September 2021, and October 2021 medication administration record (MAR) revealed: -There was an entry for Diphenoxylate HCL/Atropine take two tablets four times daily for two days as needed for diarrhea. -There was documentation Diphenoxylate HCL/Atropine was administered twice in August 2021 and September 2021. -There was no other documentation	{C 367}		

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{C 367}	Continued From page 25 Diphenoxylate HCL/Atropine was administered. Review of Resident #1's control substance count sheets (CSCS) revealed: -There was a CSCS log dispensed with Resident #1's Diphenoxylate HCL/Atropine on 07/12/21 for 30 tablets. -There was documentation Diphenoxylate HCL/Atropine was administered on 08/16/21 and there were 28 tablets remaining and on 08/18/21 and there were 26 tablets remaining, on 09/06/21 and there were 24 tablets remaining and on 09/07/21 and there were 22 tablets remaining. Observation of Resident #1's medications on hand on 10/07/21 at 10:32am revealed: -There was a medication punch card for Diphenoxylate HCL/Atropine dispensed on 10/06/16 for 16 tablets. -There were 16 tablets available to be administered. -There were no other punch cards of Diphenoxylate HCL/Atropine available. Interview with the medication aide (MA) on 10/07/21 at 10:32am revealed: -She sent Resident #1's twenty-two tablets of Diphenoxylate HCL/Atropine back to the pharmacy in September 2021. -She did not know why she sent the Diphenoxylate HCL/Atropine back to the pharmacy. -She did not document sending the Diphenoxylate HCL/Atropine back to the pharmacy. Telephone interview with the pharmacist from the facility's contracted pharmacy on 10/08/21 at 11:24am revealed: -There was no record of return for Resident #1's Diphenoxylate HCL/Atropine at the pharmacy.	{C 367}		

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{C 367}	Continued From page 26 -The facility should document the return of medication when medication was sent back to the pharmacy. -There was no reason Resident #1's Diphenoxylate HCL/Atropine would have been returned, the medication had not expired, there was no change in the dose or directions. -The medication should be accounted for or documentation of the return. Interview with the Assistant Administrator on 10/08/21 at 2:03pm revealed: -The MA should have documented when the Diphenoxylate HCL/Atropine was sent back to the pharmacy. -The Administrator was the only staff authorized to dispose of medication. -She did not know the Diphenoxylate HCL/Atropine would have been sent back to the pharmacy.	{C 367}		
{C 368}	10A NCAC 13G .1008 (b) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure the controlled medication was stored under double lock for 1 of 1 sampled resident (#1) with an order for sleeping medication.	{C 368}		

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{C 368}	Continued From page 27 The findings are: Review of Resident #1's current FL-2 dated 04/15/21 revealed: -Diagnoses included tardive dyskinesia, depression, schizophrenia, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism, and a history of a cerebrovascular accident. -There was an order for Zolpidem (used to treat insomnia) 5mg, take one tablet at bedtime. Observation of the medication room on 10/07/21 at 8:01am revealed: -There were plastic bins for each resident's medication sitting on an open shelf. -Resident #1's medications were in a bin labeled with her name. -There was a clear lockable box located on the same shelf, beside Resident #1's medications. -The door to the medication room had a lock and was locked. Observation of Resident #1's medications on hand on 10/07/21 at 10:20am revealed: -Resident #1's Zolpidem punch card was blue in color and had the letter C in red stamped on the pharmacy's dispensing label. -The punch card for Zolpidem was kept in Resident #1's bin of medication, not in the lockable box with the other controlled medications. Interview with the medication aide (MA) on 10/07/21 at 10:37am revealed: -Resident #1's Zolpidem was not stored in a separate locked container. -Resident #1 was administered Zolpidem at bedtime with other medications.	{C 368}		

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{C 368}	Continued From page 28 -Resident #1's Zolpidem was kept with the other bedtime medications. -She did not think about Zolpidem being a controlled medication and it should have been locked with the other controlled medication. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/07/21 at 4:02pm revealed Zolpidem Tartrate was a controlled medication and should be in the controlled medication box to ensure the medication was double locked. Interview with the Administrator on 10/07/21 at 2:03pm revealed: -There was a lockable box for the controlled medication to be stored and locked in. -She did not know Resident #1's Zolpidem was not being locked in the lockable box. -She expected all controls to be double locked.	{C 368}		
{C 612}	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by	{C 612}		

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{C 612}	Continued From page 29 the facility. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) were implemented when caring for four residents during the global Coronavirus (COVID-19) pandemic as related to the screening of staff and visitors. The findings are: Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes and Long-Term Facilities dated 09/10/21 revealed: -Staff should ask residents to report if they feel feverish, any symptoms consistent with COVID-19 or acute respiratory infection. -Staff should actively monitor all residents daily for fever and symptoms consistent with COVID-19. Review of the Centers for Disease Control and Prevention (CDC) Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated 03/29/21 revealed all residents and staff should screen daily for symptoms consistent with COVID-19 (fever or chills, cough, shortness of breath or difficulty of breathing, fatigue,	{C 612}			

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{C 612}	Continued From page 30 headache, body aches, loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. Review of the NC Department of Health and Human Services COVID-19 Long Term Care (LTC) Infection Control Assessment and Response Tool for local health department (LHD) dated 10/2020 revealed staff and residents should be screened daily for fever, signs and symptoms of COVID-19. Review of the NC Department of Health and Human Services guidelines dated 05/05/21 revealed: -Everyone who enters a healthcare facility shall be screened for signs and symptoms of COVID-19 by temperature checks, screening questions and observations of signs and symptoms. -Establish a process to ensure visitors entering the facility are assessed for symptoms of COVID-19 and temperatures are checked. Observations upon entering the facility on 10/07/21 between 8:00am-8:30am revealed: -The staff was sitting outside with the residents. -The staff identified themselves as a medication aide (MA). -The MA did not check the surveyor's temperature or ask any screening questions. -When asked about checking the surveyor's temperature the MA when to the office and returned with a thermometer that was not working. -The day shift MA arrived and was not screened. Interview with the MA on 10/07/21 at 8:05am revealed: -She worked the night shift and there were no	{C 612}		

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{C 612}	Continued From page 31 visitors that needed to be screened so she did not think about screening the surveyor. -She did not take the resident's temperatures, so she did not know the thermometer was not working. Interview with four residents on 10/07/21 between 8:14am-9:40am revealed: -No one had taken their temperatures at the facility. -No one asked screening questions about symptoms of COVID-19. Observation of the facility on 10/07/21 at 9:21am revealed: -A male staff from another facility brought a thermometer to the facility. -The MA took all the resident's temperatures and her temperature; all were within normal range. Interview with the MA on 10/07/21 at 9:25am revealed: -She did not check the resident's temperatures every day, but the primary care provider (PCP) checked the resident's temperatures twice a month during her visits. -She did not check her own temperature prior to entering or once she had entered the facility. -She did not screen anyone for symptoms related to COVID-19 prior to entering the facility because no one had been at the facility while she was working except for the PCP. -The previous surveyor had talked to her about taking the resident's temperatures every day, but the Administrator nor Assistant Administrator had told her to do it. Interview with the Assistant Administrator on 10/07/21 at 2:00pm revealed: -The MA on duty was responsible for checking	{C 612}			

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{C 612}	Continued From page 32 the resident's temperatures daily. -She did not know the MA's were not checking the resident's temperatures daily. -The staff should be checking their temperature daily and screening for COVID-19. -All staff were instructed to do screening for COVID-19 after the last survey, 07/14/21. -She expected the MA to check the resident's temperature, their own temperature, and screen for COVID-19, daily.	{C 612}		
{C 912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration, health care, and infection prevention. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to refer 2 of 2 sampled diabetic residents (#1 and #2), who needed their toenails trimmed (#1, #2) and a large callus on the bottom of her foot debrided (#2) to a podiatrist. [Refer to Tag 0246 10A NCAC 13G .0902(b) Health Care (Unabated Type B violation)].	{C 912}		

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{C 912}	Continued From page 33 2. Based on observations, interviews, and record review the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #1) related to a medication used to treat type II diabetes mellitus. [Refer to Tag 0330 10A NCAC 13G .1004 (a) Medication Administration (Unabated Type B violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 2 of 2 sampled diabetic residents (#1, #2) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. [Refer to Tag D932, G.S. 131D-4.4A(b)(1) Adult Care Home Infection Prevention Requirements (Type B violation)].	{C 912}		
C 932	G.S. 131D 4.4A (b) ACH Infection Prevention Requirements 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable	C 932		

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C 932	Continued From page 34 patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 2 of 2 sampled diabetic residents (#1, #2) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. The findings are:	C 932		

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C 932	Continued From page 35 Review of the Center for Disease Control and Prevention (CDC) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Review of the facility's diabetic manual policy and procedure revealed: -Operating a glucose meter must meet recognized standards for infection prevention, quality control, and health and safety. -The meter should be used in accordance with the manufacturer's recommendations. Observation of the facility's medication treatment cart on 06/02/21 at 3:19pm revealed: -There were two glucometer cases that each contained a glucometer (Brand A). -The cases were labeled with the residents' names, but the individual glucometers were not labeled. Review of the manufacturer's manual for Brand A glucometer revealed: -There was no information related to single or multiple person use of the glucometer. -There was documentation to consult your healthcare professional (this may be your doctor, pharmacist, or diabetes nurse educator) for instructions on how to use the system. Telephone interview with the pharmacist for the facility's contracted pharmacy on 10/07/21 at 4:02pm revealed: -Each resident should have their own glucometer	C 932		

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C 932	Continued From page 36 for checking finger stick blood sugar (FSBS). -Sharing glucometers put the residents at risk for cross-contamination for blood-borne illness and disease. 1. Review of Resident #1's current FL-2 dated 04/15/21 revealed diagnoses included schizophrenia, chronic obstructive pulmonary disease (COPD), hypothyroidism, and history of cerebrovascular accident. Review of Resident #1's physician's orders dated 08/16/21 revealed there was an order for fingerstick blood sugar (FSBS) twice a day. Review of Resident #1's blood sugar form revealed: -Resident #1's FSBS result for 10/07/21 was documented as 142 at 7:00am. -Resident #1's FSBS result for 10/04/21 was documented as 74 at 7:00am. -Resident #1's FSBS result for 10/03/21 was documented as 236 at 7:00am. -Resident #1's FSBS result for 10/02/21 was documented as 117 at 7:00am -Resident #1's FSBS result for 09/26/21 was documented as 114 at 7:00am. Review of the memory in Resident #1's glucometer on 10/07/21 at 10:57am revealed: -The date on the glucometer was 10/06/21 and the time was 10:55am which was a variance of one day and two minutes. -There was no reading recorded as 142 on 10/06/21. -On 10/03/21 at 5:49am there was a FSBS reading recorded as 74; the next recorded FSBS was 95 at 6:06am. -There was no reading recorded as 236 on 10/02/21.	C 932			

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C 932	Continued From page 37 -On 10/01/21 at 7:22am there was a FSBS reading recorded as 105; the next recorded FSBS was 117 at 7:24am. -There was no reading recorded as 114 on 09/25/21. -There were three readings documented that were not in the memory for Resident #1's glucometer. -There were two readings in the memory for Resident #1's glucometer, that were documented on another resident's blood sugar form for the corresponding dates. Interview with Resident #1 on 10/07/21 at 8:06am revealed: -Her FSBS was not checked every day. -She thought her FSBS was supposed to be checked twice a day. -The night medication aide (MA) checked her FSBS today, 10/07/21. -She did not recall what the FSBS reading was. Telephone interview with the nighttime MA on 10/07/21 at 3:27pm revealed: -She worked 7:00pm-7:00am. -She checked Resident #1's FSBS this morning, 10/07/21. -She used another resident's glucometer to check Resident #1's FSBS today, 10/07/21. -She had used another resident's glucometer to check Resident #1's FSBS on other days but she did not recall when. -Resident #1's FSBS glucometer needed batteries because the glucometer was "acting up" this week. -She had told another MA, Resident #1's glucometer was not working correctly, and she thought it needed batteries. Interview with a second MA on 10/08/21 at	C 932		

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C 932	Continued From page 38 10:50am revealed: -No one had told her Resident #1's glucometer was not working correctly. -Resident #1's glucometer had been showing an error code at times but then later would work fine. Refer to the telephone interview with the night MA on 10/07/21 at 3:27pm. Refer to the interview with a second MA on 10/08/21 at 10:50am. Refer to the interview with the Assistant Administrator on 10/07/21 at 2:04pm. Refer to the telephone interview with the facility's primary care provider (PCP) 10/08/21 at 11:55am. 2. Review of Resident #2's current FL-2 dated 04/15/21 revealed: -Diagnoses included type 2 diabetes, schizophrenia, hypertension, chronic obstructive pulmonary disease (COPD), and arthritis. -There was an order to check Resident #2's finger stick blood sugar (FSBS) once daily. Review of Resident #2's blood sugar form revealed: -Resident #2's FSBS result for 09/25/21 was documented as 126 at 7:00am. -Resident #2's FSBS result for 09/26/21 was documented as 148 at 7:00am. -Resident #2's FSBS result for 09/27/21 was documented as 104 at 7:00am. -Resident #2's FSBS result for 10/02/21 was documented as 105 at 7:00am. -Resident #2's FSBS result for 10/03/21 was documented as 94 at 7:00am. -Resident #2's FSBS result for 10/04/21 was	C 932		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/08/2021
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
(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	
C 932	Continued From page 39 documented as 95 at 7:00am. -Resident #2's FSBS result for 10/07/21 was documented as 103 at 7:00am. Review of the memory in Resident #2's glucometer on 10/07/21 at 11:23am revealed: -The date on the glucometer was 03/27/21 and the time was 8:35am which was a variance of four months, twenty days, and two hours and forty-eight minutes. -There was no reading recorded as 126 for the date that corresponded with 09/25/21. -There was no reading recorded as 104 for the date that corresponded with 09/27/21. -There was no reading recorded as 105 for the date that corresponded with 10/02/21. -There was no reading recorded as 95 for the date that corresponded with 10/04/21. -On 03/16/21 at 4:10am there was a reading recorded as 114; the next recorded FSBS was 115 at 4:11am. -On 03/23/21 at 3:43am there was a reading recorded as 94; the next recorded FSBS was 236 at 3:45am. -On 03/27/21 at 3:26am there was a reading recorded as 142; the next recorded FSBS was 103 at 3:31am. Interview with Resident #2 on 10/07/21 at 8:06am revealed: -Her FSBS was not checked every day. -Her FSBS was supposed to be checked once a day. -The night medication aide (MA) checked her FSBS today, 10/07/21, and her FSBS reading was 103. -She had her own glucometer, but she had not paid attention to the glucometer when her FSBS was checked.	C 932			

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NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
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C 932	Continued From page 40 Refer to the telephone interview with the night MA on 10/07/21 at 3:27pm. Refer to the interview with a second MA on 10/08/21 at 10:50am. Refer to the interview with the Assistant Administrator on 10/07/21 at 2:04pm. Refer to the telephone interview with the facility's primary care provider (PCP) 10/08/21 at 11:55am. _____ Telephone interview with the night MA on 10/07/21 at 3:27pm revealed: -Each resident had their own FSBS glucometer. -She always wiped the glucometer with alcohol between uses. -No one had told her she should not share glucometers. Interview with a second MA on 10/08/21 at 10:50am revealed: -There were two residents who had their FSBS checked twice daily. -Each resident had their own glucometer, lancets, and strips. -She had never shared a glucometer between the residents. -She could not explain why the FSBS readings from one resident were documented in another resident's record. Interview with the Assistant Administrator on 10/07/21 at 2:04pm revealed: -Glucometers should not be shared, every resident had their own glucometer. -The MAs knew glucometers should not be shared. -She expected each residents' FSBS to be	C 932			

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NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
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C 932	Continued From page 41 checked with their glucometer and the glucometer be put away before the next resident's FSBS was checked to avoid sharing glucometers. -Resident's glucometers should not be shared because of the risk of infection. Telephone interview with the facility's primary care provider (PCP) 10/08/21 at 11:55am revealed: -Each resident should have their own glucometer. -Glucometers should not be shared, "it was not a good practice to share glucometers." The facility failed to implement infection control procedures consistent with CDC guidelines resulting in sharing glucometers between residents which placed residents at risk for possible exposure to bloodborne pathogens diseases. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/08/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 22, 2021.	C 932		