STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345350	A. BUILDING _____ B. WING _____	C 06/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND TERRACE	2300 ABERDEEN BLVD GASTONIA, NC 28054

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The original recertification/complaint survey was conducted from May 31--June 2, 2011. Based upon management review, the survey dates were extended. The survey team reentered the facility on June 7, 2011and notified the administrator of the IJ at F441. The exit date was extended to June 7, 2011 at which time the jeopardy was removed and F441 was left out of compliance at a lower scope and severity. No deficiencies were cited as a result of complaint investigation survey event ID #D3BS11.	F 000	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herin. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to attempt to reduce or remove a physical restraint for one (1) of one (1) sampled residents with physical restraints (Resident #10). The findings are: 1. Resident #10 was admitted to the facility on 7/7/08 with diagnoses that included Alzheimer's disease, depressive disorder, and hypertension among others. The most recent Minimum Data Set (MDS) dated 5/24/11 specified the resident had short and long term memory impairment and	F 221	Resident #10 assessed for the need of the identified restraint. Restraint removed from Resident #10, as the assessment revealed no medical symptom evident to support the justification for restraint use. All residents identified as having the potential to be affected. Director of Nursing completed audit of all current residents to identify any resident who may have a physical restraint in use without documentation of a medical symptom. Inservice completed by Staff Development Coordinator for licensed nursing staff related to the use of a physical restraint and the justification required for the use of a physical restraint.	6/30/11 6/30/11 6/30/11 6/30/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly K. Poore — TITLE: NHA — (X6) DATE: 6/28/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 severely impaired cognitive skills for daily decision making. The MDS also specified the resident used a walker and wheelchair for mobility, was not steady moving from seated to standing position and ambulated with assistance in her room and on the secured unit of the facility and had not fallen. The MDS also specified the resident was not restrained. Resident #10's care plan for cognitive loss updated 5/24/11 specified "I will have a self-release seatbelt in my wheelchair and a pin alarm in it and a pad alarm in my bed due to my decreased safety awareness." A document titled "Fall Risk Assessment" dated 4/26/11 specified Resident #10 was ambulatory, had a balance problem while standing and walking, and was disoriented at all times. The assessment also specified the resident had not fallen in the past three (3) months. A physician's order dated 4/13/09 for "self-release belt when in wheelchair for safety." Review of the medical record revealed nurses' entries dated 4/25/11, 5/16/11, 5/26/11 and 5/30/11 revealed the resident had a self-release seatbelt fastened while she was in her wheelchair secondary to decreased safety awareness. The nurses' entries also specified Resident #10 ambulated with a walker and assistance from staff. Further review of the medical record revealed no attempts to reduce or use a less restrictive device for Resident #10 had been made by the facility. The following observations were made of Resident #10:	F 221	Restraint Monitoring Tool implemented to track and manage the use of physical restraints and to ensure evidence of a medical symptom to support the use of the restraint. The Restraint Monitoring Tool will be completed by the RN Supervisor. The Restraint Monitoring Tool will be completed oncedaily for two weeks; then three times weekly for two weeks; then once weekly for two weeks; then once monthly for two months. The Restraint Monitoring Tool will be incorporated into the Facility's Quality Assurance Program to monitor compliance and evaluate effectiveness.	6/30/11

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F 221	Continued From page 2 - On 5/31/11 at 2:00 p.m. Resident #10 was seated in her wheelchair with a Velcro self-release seatbelt fastened. Nurse aide #1 (NA) was observed to remove the seatbelt and assist the resident with transferring from her wheelchair to the bed. - On 5/31/11 at 5:35 p.m. during the evening meal Resident #10 was in her wheelchair with the Velcro seatbelt fastened. - On 6/1/11 at 8:15 a.m. during the breakfast meal Resident #10 was seated in her wheelchair with her seatbelt fastened. Observations made throughout the survey from 5/31/11 to 6/1/11 revealed the resident made no attempts to stand or remove the Velcro self-release seatbelt. NA #4 was interviewed on 5/31/11 at 2:30 p.m. and reported Resident #10 was able to ambulate with her walker and assistance of one person. NA #1 reported that Resident #10 was to have a seatbelt fastened at all times while she was in her wheelchair and stated that Resident #10 was unable to release the seatbelt on command. On 6/1/11 at 3:20 p.m. licensed nurse (LN) #4 assigned to care for Resident #10 was interviewed and stated Resident #10's seatbelt "was a restraint." She reported that the resident was unable to release the seatbelt on command and confirmed the resident made attempts to get out of the wheelchair. On 6/1/11 at 3:30 p.m. the Director of Nursing (DON) was interviewed and reported she defined a physical restraint as a device that restricted a resident's freedom to move and a device that a	F 221		

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F 221	Continued From page 3 resident could not easily remove. She confirmed that Resident #10's seatbelt did not restrain the resident because the resident was non-ambulatory and unable to rise out of the wheelchair. The DON reviewed nurses' entries and interviewed licensed staff who worked with Resident #10 and was made aware that Resident #10 used a walker to ambulate with staff and was able to rise from a seated to standing position with minimal assistance from staff. The DON stated that Resident #10 had been considered to not be restrained by the facility and no attempts to change or reduce the seatbelt had been made since the original physician's order dated 4/13/09. She confirmed that the resident had used the self-release seatbelt in a wheelchair since 4/13/09 and that no attempts to remove or use a less restrictive device had been attempted. On 6/1/11 at 3:45 p.m. the Unit Manager was interviewed and reported she was aware Resident #10 was able to ambulate with a walker. She also reported she did the fall risk assessment form on 4/26/11 on Resident #10 but was unaware that the resident's ability to stand, ambulate and inability to release the seatbelt on command restrained the resident. On 6/1/11 at 3:50 p.m. MDS Coordinator #1 was interviewed and reported the facility had no residents with physical restraints.	F 221		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow the care plan for one (1) of thirteen (13) sampled residents (Resident #4). The findings are: Resident #4 was readmitted to the facility on 08/11/2010 with diagnoses which included status post right hip fracture, history of left hip fracture, osteoporosis, degenerative joint disease, organic brain syndrome, difficulty in walking, muscle weakness and coronary artery disease. The most recent quarterly Minimum Data Set (MDS) dated 03/16/2011 coded Resident #4 with moderately impaired cognition. The MDS also specified Resident #4 required extensive assistance with transfers and was non-ambulatory. The Restraints section of the MDS indicated that siderails were not used. A review of the undated Resident Status and Care Plan utilized by nursing assistants indicated Resident #4 was to have no siderails. A nursing note dated 5/26/2011 at 6:10 a.m. stated Resident #4 attempted to get out of bed without assistance, the pad alarm sounded and the resident was found trying to stand on the blue floor mat between the rails. Resident #4 was observed on 5/31/2011 at 2:20 p.m. in bed with 1/4 length siderails raised at the	F 282	Siderails removed from the bed for Resident #4. All residents identified as having the potiential to be affected by siderail use without careplan documentation. Administrator completed audit of all beds in the Facility to identify beds with siderails. MDS Coordinator completed audit to identify resident's with and without careplan for siderail use. Careplans updated/corrected related to the use of siderails. Inservice conducted for nursing staff by the Staff Development Coordinator related to "Siderail Use" and appropriate "Care Plan". Siderail Monitoring Tool implemented to monitor the use of siderails and ensure the appropriate careplan. Siderail Monitoring Tool to be completed by the RN Supervisor daily for two weeks; then three times weekly for two weeks; then once weekly for two weeks; then once monthly for two months. Siderail Monitoring Tool incorporated into the Facility Quality Assurance Program to monitor compliance and evaluate effectiveness.	6/30/11 6/30/11 6/30/11 6/30/11 6/30/11

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F 282	Continued From page 5 top and bottom on both sides of the bed. A thick blue pad extending the full length of the bed was placed on the floor beside the bed. Resident #4 had a tab alarm connected to the back of her gown and a pressure pad alarm was in place on the bed under her. On 06/02/2011 at 8:55 a.m., Nurse Aide (NA) #1 was observed transferring Resident #4 back to bed after breakfast. Once in bed and alarms activated, NA#1 raised the 1/4 length siderails at the top and bottom on both sides of the bed and placed the blue pad on the floor beside the bed. At this time, NA #1 stated she always raised the four siderails when Resident #4 was in bed. She further stated she was not aware Resident #4's care plan indicated no siderails. An interview with the Director of Nursing on 06/02/2011 at 11:35 a.m. revealed the siderails on Resident #4's bed should not have been used especially the ones at the foot of the bed. She stated the rails had been removed from the bed today.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to rinse and dry the	F 312		

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F 312	Continued From page 6 skin prior to applying a moisture barrier cream on one (1) of six (6) sampled residents after the provision of incontinence care. (Resident #6) The findings are: Review of the facility's "Guidelines for Perineal Care" dated 2004 indicated after cleansing the perineal area, dry all areas and apply protective ointment if required. Review of the manufacturer's instructions on the use of the moisture barrier ointment used by the facility revealed in part; cleanse area, allow to dry and apply ointment liberally as needed. Instructions on the use of personal body wash products indicated apply body wash with water, gently cleanse skin, rinse and dry off. Resident #6 was admitted to the facility with diagnoses including Alzheimer's disease, Dementia and Renal Insufficiency among others. The most recent Minimum Data Set (MDS) indicated Resident #6 had severely impaired cognitive skills for daily decision making and was rarely understood or rarely understands. The MDS also indicated the resident was incontinent of both bowel and bladder and required total assistance with transfer, bathing and toilet use. On 06/02/11 Nursing Aide (NA) #3 was observed providing perineal care to Resident #6 at 9:35 a.m. During the observation, NA #3 prepared a basin with the resident's personal body wash product, removed the resident's brief and cleansed the resident's perineal area. Without rinsing or drying the resident's skin, NA #3 applied a moisture barrier ointment to the	F 312	Skin Assessment completed for Resident #6 to identify any skin breakdown related to Perineal Care. All residents dependent on nursing staff for perineal care identified as having the potential to be affected. Audit completed to identify all residents dependent on staff for perineal care. Inservice provided to CNA's by the Staff Development Coordinator related to proper Perineal Care. Perineal Care Observation Monitoring Tool implemented to ensure compliance of proper perineal care. Perineal Care Observation Monitoring Tool to be completed by the RN Supervisor. This tool to be completed on each shift, daily for two weeks; then on each shift, three times weekly for two weeks; then each shift, once weekly for two weeks; then each shift, once monthly for two months. The Perineal Care Observation Monitoring Tool to be incorporated into the Facility Quality Assurance Program to monitor compliance and evaluate effectiveness.	6/7/11 6/30/11 6/30/11 6/30/11

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F 312	Continued From page 7 resident's buttocks, placed a clean brief and re-dressed Resident #6. During an interview on 06/02/11 at 9:40 a.m., NA #3 acknowledged not rinsing or drying the resident prior to applying a moisture barrier ointment to her buttocks. She stated she was unaware of the need to rinse the resident's skin after using the body wash product. An interview with the Director of Nursing (DON) on 06/02/11 at 10:00 a.m. revealed she would expect the NA to dry the resident off before applying a moisture barrier to the skin.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to place portable oxygen cylinders in racks designated for storage in one (1) of one (1) oxygen storage room. The findings are: Review of the facility policy "Compressed Gas Cylinder Safety" last reviewed by the facility on 08/2010 indicated compressed gas cylinders shall	F 323		

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F 323	Continued From page 8 be stored in storage racks. Observation on 05/31/11 at 2:00 p.m. revealed oxygen cylinders were stored in a small storage room located within a larger room used by staff for meals and meetings. There were thirteen (13) portable oxygen cylinders standing vertically on the floor outside the metal storage racks which were designated for oxygen cylinder storage. Interview with the housekeeping supervisor on 5/31/11 at 2:30 p.m. revealed the oxygen cylinders should be stored in the metal racks. She then, proceeded to place the cylinders in the appropriate racks. An interview with the Director of Nursing (DON) on 05/31/11 at 3:00 p.m. revealed her expectation was that staff should place the oxygen cylinders in the designated racks. On 6/7/11 at 11:40 a.m. the Clinical Manager was interviewed and reported she monitored the oxygen storage room randomly several days a week. She stated she never observed oxygen cylinders stored outside the designated racks. During an interview on 6/7/11 at 3:00 p.m. the Ward Clerk stated she checked the oxygen cylinders weekly and could not recall an instance where the oxygen cylinders were stored improperly. Further interview on 6/7/11 at 4:00 p.m.with the DON revealed that portable oxygen tanks had been used by residents over the weekend (5/28/11 through 5/30/11) and staff had not replaced them in the racks when the cylinders	F 323	Portable oxygen cylinders placed in the designated storage racks. All residents identified as having the potential to be affected by improper storage of portable oxygen cylinders. Inservice provided by the Staff Development Coordinator to nursing staff related to the proper storage of portable oxygen cylinders. Monitoring Tool developed and implemented to monitor the proper storage of portable oxygen cylinders. This tool to be completed by the RN Supervisor each shift, daily for two weeks; then each shift, three times weekly for two weeks; then each shift, once weekly for two weeks; then each shift, once monthly for two months. The Oxygen Cylinder Storage Monitoring Tool to be incorporated into the Facility Quality Assurance Program to monitor compliance and evaluate effectiveness.	6/30/11 6/30/11 6/30/11 6/30/11

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F 323	Continued From page 9 were returned to the storage room.	F 323		
F 441 SS=J	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	Not withstanding the foregoing, the Facility objects to this finding of immediate jeopardy. The Facility does, in fact maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. The Facility does not have a practice of re-using "finger stick devices", otherwise known as a "lancet". Finger stick devices (lancets) are not reused between residents. However, the "testing device", otherwise known as a "Blood Glucose Meter" is the equipment used to analyze and report the result of the blood glucose test. This piece of equipment is used between residents and a policy for disinfecting this piece of equipment is evident.	

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F 441	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to a) clean or disinfect one (1) blood glucose meter (used to check blood sugar) before and/or after each use on two sampled residents (Residents #16 and #17) who shared the same blood glucose meter and b) clean one (1) blood glucose meter in a manner to adequately disinfect it before/or after performing blood glucose testing of two sampled residents (Residents #12 and #18) from a total sample of nine (9) residents Immediate Jeopardy began on 5/31/11 when Licensed Nurse (LN) #1 failed to clean and disinfect the blood glucose meter (glucometer) before use when she obtained fresh blood samples to monitor the blood sugar levels of Resident #17. Immediate Jeopardy was removed on 6/7/11 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems which were put into place and the completion of employee training. The findings are: Review of the facility policy titled "Disinfecting Blood Glucose Meters" dated 11/2/2010 revealed the following: "Blood glucose meters will be	F 441	Resident #16 and #17 evaluated to identify any signs and/or symptoms of infection related to Bloodborne Pathogens. Residents #18 and #12 evaluated to identify any signs and/or symptoms of infection related to Blood-borne Pathogens. All residents requiring blood glucose monitoring identified as having the potential to be affected. Audit completed by the Director of Nursing to identify all residents requiring blood glucose monitoring. Inservice completed by the Staff Development Coordinator for all licensed staff related to the procedure for disinfecting blood glucose meters. Blood Glucose Meter Monitoring Tool implemented to monitor compliance of proper disinfecting of the Blood Glucose Meters and ensure compliance. Blood Glucose Monitoring Tool to be completed by the RN Supervisor each shift, daily for two weeks; then each shift, three times weekly for two weeks; then each shift, once weekly for two weeks; then each shift, once monthly for two months. The Blood Glucose Meter Monitoring Tool to be incorporated into the Facility Quality Assurance Program to monitor compliance and evaluate effectiveness.	6/7/11 6/7/11 6/7/11 6/7/11

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F 441	Continued From page 11 cleaned after each use and/or between resident uses when used for more than one resident. Each device is to be thoroughly wiped with a Sani Cloth HB (or comparable product) after each use on a resident. Discard wipe into trash." 1. Medical record review revealed Resident #16 was admitted with diagnoses including post coronary artery bypass surgery, abdominal pain and pancreatitis. On 5/31/2011 at 4:45 p.m. Licensed Nurse (LN) #1 was observed performing a fingerstick blood sugar test on Resident #16. LN #1 entered the resident's room with the blood glucose meter she had removed from the medication cart. She did not clean or disinfect the blood glucose meter prior to donning gloves and inserting the glucose strip into the machine. The resident's finger was pricked using a new lancet and a drop of blood was collected on the test strip. After the test was completed LN #1 returned the machine to the top drawer of the medication cart without cleaning or disinfecting it. Review of the May 2011 Medication Administration Record (MAR) for Resident #16 revealed a pharmacy notation that instructed staff to clean the blood glucose meter with Saniwipe with HB before and after each use. Medical record review revealed Resident #17 was admitted with diagnoses including chronic renal failure, chronic obstructive pulmonary failure, diabetes and congestive heart failure. On 5/31/11 at 5:30 p.m. Licensed Nurse (LN) #1 obtained the same blood glucose meter used on Resident #16 from the medication cart and entered Resident #17's room to perform a	F 441		

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	345350	A. BUILDING _____ B. WING _____	C 06/07/2011

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F 441	Continued From page 12 fingerstick blood sugar test. LN #1 did not clean or disinfect the blood glucose meter before she donned gloves and inserted the glucose strip into the machine. The resident's finger was pricked using a new lancet and a drop of blood was collected on the test strip. After the test was completed LN #1 returned the blood glucose meter to the top drawer of the medication cart without cleaning or disinfecting it. Review of the May 2011 Medication Administration Record (MAR) for Resident #17 revealed a pharmacy notation that instructed staff to clean the blood glucose meter with Saniwipe with HB before and after each use. In an interview with LN #1 on 05/31/2011 at 6:05 p.m. she stated the blood glucose meter shared by residents on the hall should be disinfected using a bleach wipe between each resident use. She stated she did not clean the blood glucose meter after checking either Resident #16's or Resident #17's blood sugar. An interview with the Director of Nursing on 06/02/2011 at 11:30 a.m. revealed she expected that the blood glucose meters be disinfected after each use. On 6/7/11 at 5:15 p.m. the Staff Development Coordinator (SDC) and DON were interviewed together. The SDC reported she helped develop the new policy for cleaning and disinfecting blood glucose meters last year when the facility was made aware of the concern for the potential spread of blood borne pathogens with the use of the meters. She stated the blood glucose meters should be cleaned before and after each use with the Saniwipes. She confirmed she contacted	F 441		

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F 441	Continued From page 13 outside resources for additional help and attempted to develop a simple policy that all licensed nurses would understand. She specified that all licensed nurses were in-serviced on the proper technique for cleaning and disinfecting the blood glucose meters with the approved Sani Cloth HB wipes. The SDC stated that in-serving on this topic had remained on going. The SDC confirmed that licensed nurses were given verbal instructions for disinfecting the blood glucose meters and reported that return demonstrations were not part of the in-service. She added that licensed nurses who performed finger sticks were observed several months previous by the facility's pharmacy consultant. The SDC and DON both confirmed that the licensed nurses observed cleaned and sanitized the blood glucose meters correctly as reported to them by the consultant Pharmacist. The DON reported that there was no ongoing monitoring of cleaning the blood glucose meters because no concerns had been identified. The Administrator was notified of the Immediate Jeopardy on 6/7/11 at 10:40 a.m. The facility provided a credible allegation of compliance on 6/7/11 at 6:00 p.m. The following interventions were put into place by the facility to remove the Immediate Jeopardy: Licensed Nurse (LN) #1 observed on 5/31/11 not cleaning the glucose monitoring device before and after use for Resident #16 and #17 was immediately in-serviced related to the Policy and Procedure for Disinfecting Blood Glucose Meters on 5/31/11 by the Director of Nursing. One on one in-service was provided related to the importance of disinfecting blood glucose meters and the use of Sani Cloth HB (approved	F 441		

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F 441	Continued From page 14 disinfectant wipes) to prevent the spread of infection. Residents #16 and #17 showed no signs/symptoms of any blood borne pathogen as evidenced by medical record review and Residents #16 and #17. Resident medical records and infection reports dated 5/1/11 to 5/31/11 were reviewed. The Infection Control nurse reviewed and analyzed infection control reports and determined no residents who resided in the facility on 5/31/11 were identified as having blood borne pathogens. In-service education was completed for all staff responsible for obtaining blood sugars with blood glucose meters on 6/1/11. The in-services were conducted by the Director of Nursing and the Infection Control nurse. The In-services for all licensed staff included the proper procedure for obtaining specimen, the importance of disinfecting blood glucose meters between residents and the importance of using a Sani Cloth HB. On 6/1/11 the facility identified one (1) licensed nurse to be on vacation. This licensed nurse will be in-serviced prior to accepting assignment by the Infection Control nurse. The identified licensed nurse will not be scheduled for duty until documented evidence that she has completed the in-service related to disinfecting blood glucose meters. The Policy and Procedure for disinfecting blood glucose meters is included in the orientation required for new licensed staff and reviewed during in-services by the Staff Development Coordinator. An audit was completed on 6/7/11 to identify all residents requiring blood glucose monitoring by	F 441		

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F 441	Continued From page 15 reviewing pharmacy records. This review was conducted by the Director of Nursing and identified a total of twenty-one (21) residents who required blood glucose monitoring. The purpose of this review was to identify all residents who require finger sticks to complete medical record review for each resident to ascertain no residents had acquired blood borne pathogens. Medical record review for each resident was conducted by the Infection Control nurse revealed none of the twenty-one (21) identified residents exhibited signs/symptoms of blood borne pathogens. A Quality Assurance Monitoring tool was developed to ensure staff members are using a Sani Cloth HB to disinfect the blood glucose meters to ensure compliance, according to facility policy. This Quality Assurance tool was developed and implemented on 6/7/11 by the Administrator. The Quality Assurance Monitoring tool will be completed by the Charge Nurse on each shift (3). The Quality Assurance Monitoring tool will be completed daily for two (2) weeks; then three (3) times a week for two (2) weeks; then once weekly for two (2); then once monthly for two (2) months. The Quality Assurance Monitoring tool will be incorporated into the monthly facility Quality Assurance program to evaluate compliance and effectiveness. Immediate Jeopardy was removed on 6/7/11 at 6:15 p.m. A review of the facility's In-service attendance records verified licensed nurses were trained on the proper technique for cleaning and disinfecting glucometers. Interviews with licensed nursing staff who worked on the day and evening shifts confirmed that they had received recent training on how to correctly clean and disinfect	F 441		

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F 441	Continued From page 16 blood glucose meters to prevent the spread of infections and correctly explained how to disinfect glucometers by using a sani cloth HB. Observations of licensed nurses on the day and evening shifts using a blood glucose meter to monitor blood glucose levels revealed that the meter was correctly cleaned and disinfected with a sani cloth to prevent the spread of infections. 2. A continuous observation was made on 5/31/11 at 5:17 p.m. of Licensed Nurse (LN) #3 providing a finger stick blood sugar (FSBS) check on Resident #18. Prior to using the blood glucose meter on Resident #18, LN #3 cleaned the blood glucose meter with an alcohol wipe. She then proceeded to check Resident #18's FSBS. After using the blood glucose meter on Resident #18, LN #3 cleaned the blood glucose meter with an alcohol wipe. LN #3 then used the same blood glucose meter to check Resident #12's FSBS. After using the blood glucose meter she cleaned it with an alcohol wipe. An interview was conducted on 05/31/11 at 6:20 p.m. with LN #3. LN #3 reported that she was supposed to clean the blood glucose meter with a Sani Cloth. She stated there were no Sani Cloths in her medication cart. An interview conducted on 05/31/11 at 6:40 p.m. with the Director of Nursing revealed that it is her expectation that the blood glucose meters are cleaned after each use with Sani Cloth HP.	F 441		