STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345009	A. BUILDING _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT WHITAKER GLEN-MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interview the facility failed to provide full visual privacy while providing treatments for 1 of 4 residents receiving care. The findings included:	F 164	F164 This Plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the	6/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 1 Resident #128 was admitted to the facility on 2/16/16 with diagnoses of respiratory failure with hypoxia, atrial fibrillation, coronary artery disease, diabetes mellitus, congestive heart failure, hypertension and depression. Review of her most recent admission Minimum Data Set (MDS) dated 2/23/16 revealed that she was cognitively intact. On 5/17/16 at 3:34 PM, Resident # 128 was observed receiving a bladder scan. The privacy curtain at the foot of the resident ' s bed was observed with a 6 foot wide gap. The Nurse #1 was observed attempting to close the privacy curtain but stated the curtain was stuck and she could not close it. Resident #128 ' s roommate (Resident #22) was observed sitting in her wheelchair on the window side of the room while the privacy curtain was open and her roommate was observed receiving a treatment. Resident #22 was admitted to the facility on 4/17/16 with a diagnoses of a fracture of her right ankle. A review of her admission Minimum Data Set (MDS) dated 4/22/16 revealed Resident #22 was cognitively intact. Resident #22 stated on 5/17/16 at 3:40 PM when she wanted to leave the room the curtain at the end of her roommate's bed would be left open while staff were providing care. Resident #22 stated when she left the room she tried not to see her roommate getting care. Resident #22 stated it made her feel uncomfortable when staff failed to provide privacy. On 5/18/16 at 9:01 AM Nurse #1 (the nurse that	F 164	correctness of the conclusions set forth on this statement of deficiencies. The Plan of correction is prepared and submitted solely because of requirements under state and federal law. 1. Address how corrective action will be accomplished for those residents found to have been affected : Resident #22 was moved to private room on 5-17-16. Resident #128 privacy curtain was checked and replaced to ensure adequate privacy is maintained on 5/19/16 upon being notified of issues. Resident #22 concerns were addressed by DHS on 5/19/16 once made aware of concern. 2. Address how corrective action will be accomplished for those residents having potential to have been affected : Semi private rooms (privacy curtains) were checked on 5/20/16 by maintenance to ensure proper function and repairs noted and made by 5/31/16. 3. Address what measures will be put into place or systemic changes made: Staff education on maintaining privacy during care with privacy curtian provided on 5/19-5/25/16 to nurses, aides, therapists, those staff on PTO or FMLA will be educated upon return. General orientation for new nurse, aide,	

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F 164	Continued From page 2 provided a treatment to Resident #128 on 5/17/16) stated she was completing a bladder scan. She stated she " yanked and yanked " the privacy curtain but could not get it to close at the end of the bed. She stated she was aware that the privacy curtain should have been pulled around the resident while providing a treatment. During an interview on 5/19/16 at 9:29 AM the Assistant Director of Nursing stated that her expectation was to maintain a patient ' s privacy and to close the curtains before beginning a procedure especially if the resident had a roommate. During a follow up interview on 5/19/16 11:05 AM Resident #22 stated she did not know that there were 2 privacy curtains and was not aware there was a privacy curtain at the end of her roommate ' s bed until 5/17/16. During an interview on 5/19/16 2:15 PM Resident# 128 stated it did bother her that staff had not closed the privacy curtain while she was getting a treatment.	F 164	therapy hires will include education on use of privacy curtains to maintain resident privacy. DHS or designee will audit 3 semi private rooms daily for 7 days, then weekly for two weeks, and then once monthly x 1 for compliance with use of privacy curtain when providing care. Compliance rounds will be conducted randomly on a minimum of 3 rooms daily by a member of the management team to identify if privacy curtains are in need of repairs or replacements ongoing for 7 days, then weekly for two weeks, then once monthly. 4.How facility plans to monitor, evaluate, and incorporate into QAPI DHS or designee will audit 3 semi private rooms daily for 7 days, then weekly for two weeks, and then once monthly x 1 for compliance with use of privacy curtain when providing care. Compliance rounds will be conducted randomly on a minimum of 3 rooms daily by a member of the management team to identify if privacy curtains are in need of repairs or replacements for 7 days, then weekly for two weeks, then once monthly. Results of 7 day audit will be reported to the QAPI committee on 5/31/16 to determine if audits need to continue. Complaince rounds checklist will be	

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F 164	Continued From page 3	F 164	turned in to the administrator and reviewed for necessary follow up. Compliance rounds checklist will be shared during QAPI meetings to determine additional follow up if needed	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure dignity in dining by using disposable tableware for serving desserts for 42 of 69 residents who received their dessert on disposable dishes. The findings included: During the meal observation conducted on 5/18/16 between 11:48 AM to 12:25 PM it was noted all desserts were served to residents in disposable containers. In an interview with the Certified Dietary Manager on 5/19/16 at 8:42 AM he stated that they had always served cake in the disposable Styrofoam containers. He indicated that when cake is served with plastic wrap as a cover it pulls the frosting off and does not look very appealing to residents. During an interview with the Kitchen Manager on 5/19/16 at 12:48 PM she stated that when she came to the facility a year ago the kitchen was using the disposable Styrofoam containers to serve cake. She stated she was told by management that it was company policy to serve cake in the disposable containers. She stated that	F 241	F241 This Plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on this statement of deficiencies. The Plan of correction is prepared and submitted solely because of requirements under state and federal law 1. Address what corrective action will be accomplished for those residents found to have been affected: No residents identified to be affected. No grievances have been received by residents or patients for use of sytrofoam clam shells which were used to protect the integrity of the desserts.	5/25/16

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F 241	Continued From page 4 when cake is put on a plate and the plastic wrap was pulled off it messed up the frosting and decorations. During an interview with the Administrator on 5/19/16 at 1:00 PM she stated that she was not aware of any resident that complained about receiving cake in disposable containers. She indicated that residents had complained that when the cake was wrapped in plastic wrap it took all the frosting off the cake.	F 241	2. Address what corrective action will be accomplished for those residents found to have potential to be affected: All residents with potential to be affected. Ten alert and oriented residents were interviewed on 5/19/16 and all stated that the use of Styrofoam clam shells did not affect their dignity. 3.Address what measures will be put into place or systemic changes made: Use of Styrofoam clam shells for desserts was stopped on 5/19/16. Additional plates ordered on 5/19 and delivered on 5/25/16. Use of plates or bowls for desserts was implemented on 5/20/16. Dietary staff educated not to use clam shells for desserts on 5/19-5/24/16. Dietary staff on PTO or FMLA will be educated upon return. Dietary Manager or Designee will monitor tray line for 5 days, then weekly for one week, then monthly x 1 to ensure clam shells are not used for desserts General orientation for dietary staff will include education as to when to use sytrofoam products. 4. How facility plans to monitor, evaluate, and incorporate into QAPI Dietary Manager or Designee will monitor	

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F 241	Continued From page 5	F 241	tray line for 5 days, then weekly for one week, then monthly x 1 to ensure clam shells are not used for desserts Results of audit will be presented to the QAPI committee on 5/31/16 and the committee will determine need for further monitoring.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse	F 356		6/1/16

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F 356	Continued From page 6 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, document review and staff interviews, the facility failed to include in the staff posting the number of RNs (Registered Nurses), LPNs (Licensed Practical Nurses) and NAs (Nursing Assistants) that worked on the 7AM to 3PM shift and failed to post the staffing for the 3PM to 11PM and the 11PM to 7AM shifts for 1 of 3 days of the survey and failed to post the staff posting 2 of 3 days of the survey. The findings included: On 5/17/16 at 10:15AM the staff posting was observed on a bulletin board near the nurse ' s station on the 100 hall. The posting did not list the number of RNs, LPNs or NAs that worked on the 7AM to 3PM shift. On 5/19/16 at 2:43PM an observation of the staff posting on the bulletin board revealed the posting dated 5/17/16. The posting for the 3PM-11PM shift and the 11PM to 7AM shift revealed no information regarding the number of staff working or the number of hours worked by RNs, LPNs or NAs. An interview was conducted with the Administrator and the Director of Nursing (DON) on 5/19/16 at 2:43PM. The DON stated the unit manager filled out the staff posting for the morning and evening shifts and the night supervisor filled out the posting for the night shift. The DON stated apparently the unit manager did not post the staff posting on 5/18/16 or 5/19/16. The unit manager was not available for an interview.	F 356	F356 This Plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on this statement of deficiencies. The Plan of correction is prepared and submitted solely because of requirements under state and federal law 1. Address what corrective action will be accomplished for those residents found to have been affected: No residents were identified 2. Address what corrective action will be accomplished for those with potential to be affected: No residents were identified, but all with potential to be affected New staffing form developed to include number of hours and number of persons for each shift for RN, LPN, and NA. New staffing form implemented on 5/20/16.DHS or designee educated supervisors (5/19-5-24-16) on staffing hours posting requirement.	

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F 356	Continued From page 7	F 356	3. Address what measures will be put into place or systemic changes made: New staffing form developed to include number of hours and number of persons for each shift for RN, LPN, and NA. New staffing form implemented on 5/20/16. DHS or designee educated supervisors (5/15-5-24-16) on staffing hours posting requirement. General orientation for nurse supervisors will include posting of staffing hours daily. 4. How facility plans to monitor, evaluate, and incorporate in QAPI: DHS or designee will check daily to ensure staffing hours is posted with hours of each and number of each RN, LPN, NA daily for 12 days beginning 5/20/16, then weekly for two weeks, then monthly. Admin or designee will check daily for 12 days, then weekly for two weeks, then monthly to ensure staffing hours are posted as part of compliance rounds checklist. Results of audits will be presented to QAPI and committee will determine need for additional monitoring. Compliance check list will be completed daily by a member of the management team to ensure hours are posted daily and findings reported in QAPI meeting to determine if additional actions are needed.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		6/1/16

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F 371	Continued From page 8 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean the tray steam table shelf for one of two steam tables observed. The findings included: A review of the Dietary Daily Cleaning Assignments issued September, 2001: listed under Steam table: Clean/free of food debris. Under shelf/ over shelf cleaned. Glass/tray slides cleaned. During an observation on 5/18/16 at 11:47 AM the five well steam table was observed. The 5 ½ foot underside of the steam table shelf was observed to be covered with dark dried food particles. A second observation on 5/19/16 at 12:46 PM the 5 ½ foot underside of the steam table shelf was observed to be covered with dark dried food particles. The 5 ½ foot tray line shelf attached to the steam table was observed with dark dried drips 2 to 4 inches long. In an interview with the Kitchen Manager on 5/19/16 at 12:47 PM she stated that she expected staff to clean the underside of the shelf and indicated staff would do so that day. She stated	F 371	F371 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the fact alleged or the correctness of the conclusions set forth on this statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. 1. Address what corrective action will be accomplished for those residents identified: No residents were identified to be affected 2. Address what corrective action will be accomplished for those residents with potential: all residents with potential to be affected	

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F 371	Continued From page 9 that she did not know when staff had last cleaned the shelf. Review of the Dietary Daily Cleaning Assignments dated May 2016 listed under Steam table: Clean/free of food debris. Under shelf/ over shelf cleaned. Glass/tray slides cleaned was initialed and checked yes as completed.	F 371	Steam table was immediately cleaned on 5/19/2016 Dietary staff educated on proper cleaning procedure and cleaning checklist on 5-19 through 5-24-16. 3. Address what measures will be put into place or systemic changes made: Steam table was immediately cleaned on 5/19/2016 Dietary staff educated on proper cleaning procedure and cleaning checklist on 5-19 through 5-24-16. General orientation of new Dietary staff will include education on cleaning checklist. CDM or designee will inspect steam tables each day for 12 days, then weekly for two weeks, then monthly to ensure proper cleaning of steam stables. Weekly for 4 weeks the CDM or designee will check cleaning schedules to ensure compliance with cleaning checklist. 4. How will facility will monitor, evaluate, and incorporate into QAPI CDM or designee will inspect steam tables each day for 12 days, then weekly for two weeks, then monthly to ensure proper cleaning of steam stables. Weekly for 4 weeks the CDM or designee will check cleaning schedules to ensure compliance with cleaning checklist.	

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F 371	Continued From page 10	F 371	Findings will be presented to the QAPI committee and will determine the need for further monitoring/auditing.	
F 441 SS=D	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.	F 441		6/1/16

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F 441	Continued From page 11 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, facility staff failed to wash their hands during wound care for 1 of 4 residents observed to receive wound care (Resident #25) and failed to clean a glucose meter with bleach between residents for 2 of 2 residents observed to have a finger stick blood sugar check (Resident #150 and #128). The findings included: 1. On 5/18/16 at 3PM a Nurse Practitioner (NP) and Nurse #3 was observed to provide wound care for the Resident #25. Upon entering the room the NP and Nurse #3 were wearing gloves. The NP was observed to clean the resident ' s sacral wound and prior to leaving the room gave the nurse further instructions regarding the dressing. The Nurse was observed to place a debriding agent into the wound with cotton tipped applicators and packed the wound with gauze wet with saline. The nurse was observed to place an absorbent material around the outside of the wound and placed a large dressing pad over the wound and taped in place. The Nurse was observed to remove the gloves and assist the resident to turn onto her back and taped the incontinent brief in place. The nurse was observed to pick up the unused dressing materials from the bedside table and walk around the bed and place the items on a desk. The nurse discarded the gloves in the trash and donned another pair of gloves. The nurse was observed	F 441	F441 This plan of correction constituts a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the fact alleged or the correctness of the conclusions set forth on this statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law 1. Address what corrective action will be accomplished for those residents identified: Orders were obtained 5/19/16 on resident #25 to monitor g-tube site for signs/symptoms of infection for 7 days. 2. Address what corrective action will be accomplished for those residents with potential: Charts reviewed to identify two other residents with ostomy sites with potential to be affected. One identified with potential to be affected, and wound care observed to be in compliance with hand	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12 to pour normal saline onto gauze pads and cleaned around the resident ' s abdominal gastric tube insertion site. The Nurse was observed to place gauze around the gastric tube and tape in place. The Nurse was observed to discard the gloves, pick up the clean dressing materials from the desk and exit the room. The Nurse was observed to go to the medication room and place the unused supplies on a medication cart and used a hand sanitizer to clean her hands. On 5/18/16 at 3:28 PM, Nurse #3 stated in an interview she washed her hands after she finished everything. The Nurse stated she probably should have washed her hands after the dressing change on the sacrum. On 5/18/16 at 3:39 PM the Nurse Educator stated in an interview the nurse should have washed her hands prior to cleaning the gastric tube. The Nurse Educator stated once dressing supplies were taken into the room they should not have been removed from the room. 2. The manufacturer ' s manual for the glucose meter used by the facility stated the device should be disinfected with an agent approved by the EPA (Environmental Protection Agency) such as bleach. On 5/19/16 at 11:18AM, Nurse #2 was observed to check a finger stick blood sugar on Resident #150. The Nurse was observed to open a small package and remove a pad and clean the glucose meter and stated she was cleaning the glucose meter with alcohol. The Nurse was then observed to enter the room of Resident #128 and explain to the resident she needed to check her blood sugar. Prior to the nurse pricking the resident ' s finger the nurse was asked how she normally cleaned the glucose meter between residents. The Nurse stated she cleaned the glucose meter with bleach wipes before and after	F 441	hygiene technique by educator on 5.20.16. Nurse practitioner and nurse #3 were educated immediately on 5/18/16 by facility educator on proper hand hygiene technique with dressing changes. Nurse education on proper hand hygiene technique with dressing changes implemented on 5/18-5/24/16. Nurses on PTO or FMLA will be educated upon their return. DHS or designee will observe 3 dressing changes daily for 12 days, then weekly for two weeks, then once monthly to ensure compliance with hand hygiene technique with dressing changes. 3. Address what measures will be put into place or systemic changes made : Nurse practitioner and nurse #3 were educated immediately on 5/18/16 by facility educator on proper hand hygiene technique with dressing changes. Nurse education on proper hand hygiene technique with dressing changes implemented on 5/18-5/24/16. Nurses on PTO or FMLA will be educated upon their return. General nurse orientation will include proper hand hygiene technique with dressing changes. DHS or designee will observe 3 dressing changes daily for 12 days, then weekly for two weeks, then once monthly to ensure compliance with hand hygiene technique	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345009	A. BUILDING _____ B. WING _____	05/19/2016

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F 441	Continued From page 13 use but cleaned with alcohol between residents On 5/19/16 at 11:26AM an interview was conducted with the Nurse Educator who stated the glucose meter should be disinfected with bleach wipes. The Administrator was present during the interview and stated the glucose meter was to be cleaned with bleach wipes after each resident.	F 441	with dressing changes. 4. How facility will monitor, evaluate and incorporate into QAPI: Nurse practitioner and nurse #3 were educated immediately on 5/18/16 by facility educator on proper hand hygiene technique with dressing changes. Nurse education on proper hand hygiene technique with dressing changes implemented on 5/18-5/24/16. Nurses on PTO or FMLA will be educated upon their return. DHS or designee will observe 3 dressing changes daily for 12 days, then weekly for two weeks, then once monthly to ensure compliance with hand hygiene technique with dressing changes. Results of hand hygiene observations will be reported to the QAPI committee on 5/31/2016 and will determine need for further observations. 1. Address what corrective action will be accomplished for those residents identified: Resident #150 and #128 were monitored for 48 hours for any sign/symptoms of infection. 2. Address what corrective action will be accomplished for those residents with	

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F 441	Continued From page 14	F 441	potential: Charts reviewed and 9 residents receiving glucose checks identified with potential to be affected. Nurse #2 was reeducated on 5/19/16 to use bleach wipes between patient use to clean and disinfect glucometer. Nurses were educated 5-19 through 5/24/16 on glucometer cleaning and disinfecting between residents using bleach wipes. Nurses on PTO or FMLA will be educated upon return to the facility. DHS or designee will check daily 3 to 5 nurses who have residents receiving glucose checks to ensure glucometers are cleaned with bleach wipes between use for 12 days, then weekly for two weeks, then monthly on varying shifts. 3. Address what measures will be put into place or systemic changes made : Nurses were educated 5-19 through 5/24/16 on glucometer cleaning and disinfecting between residents using bleach wipes. Nurses on PTO or FMLA will be educated upon return to the facility. DHS or designee will check daily 3 to 5 nurses who have residents receiving glucose checks to ensure glucometers are cleaned with bleach wipes between	

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F 441	Continued From page 15	F 441	use for 12 days, then weekly for two weeks, then monthly on varying shifts. General nurse orientation will include education on cleaning and disinfecting glucometers with bleach wipes between patients. 4. How facility will monitor, evaluate, and incorporate into QAPI: Nurses were educated 5-19 through 5/24/16 on glucometer cleaning and disinfecting between residents using bleach wipes. Nurses on PTO or FMLA will be educated upon return to the facility. DHS or designee will check daily 3 to 5 nurses who have residents receiving glucose checks to ensure glucometers are cleaned with bleach wipes between use for 12 days, then weekly for two weeks, then monthly on varying shifts. General nurse orientation will include education on cleaning and disinfecting glucometers with bleach wipes between patients. Results of audit will be reported to the QAPI committee on 5/31/16 and the committee will determine the need for additional monitoring.	