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	345465	A. BUILDING ______ B. WING ______	C 10/12/2017

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of this complaint investigation survey of 10/12/17. Event ID 06PQ11.	F 000		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards	F 309		11/4/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 11/02/2017

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 309	Continued From page 1 of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff, and Physician Assistant interviews, and record review the facility failed to provide scheduled pain medication as ordered by the physician for 1 of 1 residents (#29). A record review revealed Resident #29 was readmitted to the facility on 02/17/15. His documented diagnoses included pain in right shoulder, pain in left shoulder, Alzheimer's Dementia, Paroxysmal Atrial Fibrillation, Essential Hypertension, Glaucoma and Heart Disease. The Quarterly Minimum Data Set dated 08/14/17 revealed he had moderately impaired cognition, required one person physical assistance with activities of daily living, and used a wheelchair for mobility. It also documented that he was on a scheduled pain medication regimen. A record review of his care plan dated 09/01/17 revealed that Resident #29 was at risk for alteration in comfort with the following interventions documented: 1. Monitor and document pain level every shift and as needed 2. Assist with turning and repositioning for comfort 3. Administer pain medication as ordered 4. Monitor effectiveness of pain medication; if ineffective notify physician A review of the October 2017 Medication Administration Record (MAR) revealed the	F 309	Bayview Nursing & Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The below response to the Statement of Deficiency and plan of correction does not denote agreement with citation by Bayview Nursing and Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings. F309: The MD/Practitioner ordered Aleve 220mgs by mouth at breakfast and at supper for resident #29: diagnoses of pain in right and left shoulder. On 10/9/17 the facility failed to give the 9:00AM dose as ordered by the MD/Practitioner because the charge nurse did not find the Aleve in the medication cart and assumed that the facility was out of the medication before contacting each nurse□s station to see if there was Aleve (stock drug) in any of the other medication carts. Assuming the facility was out of the Aleve charge nurse	

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following physician orders:

1. Naproxen Sodium (Aleve) 220 mg by mouth at breakfast and supper
2. Tylenol 325 mg by mouth (2) tabs every six hours

An additional record review of the MAR showed that Aleve was given to Resident #29 at 8:00 AM on Sunday 10/08/17, was not given at 4:00 PM on 10/08/17 or at 8:00 AM on 10/09/17.

In an interview conducted on 10/09/17 at 3:06 PM with Resident #29 and a family member he stated that he was in pain because he had not received his Aleve. He said morning Nurse #2 told him the facility was out of Aleve. The family member reported she had asked again at 2:00 PM on 10/09/17 and Nurse #2 told her the facility was out of Aleve.

In an interview conducted on 10/10/17 at 1:55 PM with Nurse #2 she revealed that the facility had been out of Aleve. She said she had worked second shift on 10/08/17 and then worked again on day shift on 10/09/17 passing medications on Resident #29's hall both shifts. She stated that Resident #29 was out of the facility on 10/08/17 at supper time and did not return until around 9:00 PM. Nurse #2 stated because she did not administer Resident #29's medications at supper time on 10/08/17, she was unable to state if the facility was out of Aleve on that day but did notice on the morning of 10/09/17 that the Aleve bottle was empty. She stated she did not offer Resident #29 an alternate pain medication and had not contacted the physician regarding the missed doses of Aleve. She revealed that the Director of Nursing went to a local store on 10/09/17 in the

F 309

documented the medication was not available.

On 10/9/17 the 5:00PM 220 mg dose of Aleve was administered to the resident #29 as ordered.

The charge nurse is expected to check the medication stock room, the other medications carts and notify the Director of Nursing/Clinical Care Coordinator before assuming the facility is out of the medication.

The charge nurse is expected to notify the MD/practitioner if the medication is not available to give to the resident.

It is the intent of the facility to ensure pain management for resident #29 and all other residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents� goals and preferences.

Nurse #2 was in-serviced on 10/12/17 on:Administering medications as ordered by the MD/Practitioner. The nurse must notify the Director of Nursing/Clinical Care Coordinator if unable to find medications. The nurse must notify MD if medication is not available to administer as ordered.

Nursing staff RN�s LPN�s and MA�s were in serviced on 10/12/17 on: :Administering medications as ordered by the MD/Practitioner. The nurse must notify

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F 309	Continued From page 3 afternoon and purchased Aleve so Resident #29 had received his scheduled dose of Aleve at 5:00 PM on 10/09/17. In an interview conducted with the Director of Nursing on 10/10/17 at 11:05 AM she revealed it was her expectation that if a nurse discovered she did not have a medication to administer the nurse would call the pharmacy for medication replacement. She stated if it was known that there would be a delay in delivery, she would expect the nurse to contact the physician to notify him of the medication omission or to get an alternative order. She would also expect the nurse to notify the responsible party. In a telephone interview with the Physician's Assistant on 10/12/2017 at 11:23 AM, she stated if a resident was out of a medication she expected the facility to let her know and to also call the pharmacy to get the medication into the facility. She said there was no excuse for this resident to run out of Aleve because he had been on it for at least the year since she has been servicing this facility. She reported the resident had severe arthritis and needed the medication. She said this was the first she had heard that the resident had missed doses of Aleve and she had been in the facility on Tuesday (10/10/17). She expected the nurses to let her know when any medication was not given and she revealed she had not been notified. She said the nurses who had been dispensing the medication should have known it was about to run out and should have had it reordered so that it was available to the resident.	F 309	the Director of Nursing/Clinical Care Coordinator if unable to find medications. The nurse must notify MD if medication is not available to administer as ordered. The Director of Nursing/Supply Clerk will monitor stock medications weekly using the PAR stock work sheet to make sure that PAR stock levels are maintained. Stock medications will continue to be ordered weekly on Tuesdays. Any identified problems related to PAR stock monitoring will be reported to the QI Committee by Administrator/Director of Nursing. The Director of Nursing will report the monitoring results to the QA Committee monthly times 3 months, X1 quarterly and as needed. Identified problems will be corrected immediately to maintain regulatory compliance.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		11/4/17

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(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 441	Continued From page 5 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to disinfect the glucometer between resident uses according to manufacturer's recommendations for 1 of 2 resident's observed for glucometer checks (Resident #54). Findings included: Review of the facility's policy and procedure on cleaning glucometers last reviewed 8/18/11 revealed that the glucometers were to be cleaned	F 441	F441 The facility ordered new clean/disinfected wipes in March 2017 and implemented them using the same cleaning/disinfecting process as the previous wipes. The old product instructions was clean and disinfect for one minute the new product was clean and disinfect for four minutes. On 10/11/17 nurse #1 failed to clean and disinfect the glucometer for (4) four	

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per manufacturer's instructions.

Review of the facility's glucometer user instruction manual revised 11/2012 revealed the glucometer was to be cleansed with a commercially available registered disinfectant detergent or germicide wipe. To use a wipe, the instructions were to follow the product label instructions of the wipe to disinfect the glucometer.

Review of the directions on the germicidal wipes used by the facility for cleaning glucometers on 10/11/17 at 12:01 PM revealed the surface to be cleaned was to remain visibly, thoroughly wet for a full four minutes, using additional wipes if needed to assure continuous four minutes of wet contact time. The surface was then to be let air dry.

During observation on 10/11/17 at 12:04 PM, Nurse #1 was observed to check Resident #69's blood sugar level with a glucometer. After checking this resident's blood sugar, she then wiped the glucometer for approximately seven seconds with the facility's germicidal wipe and placed it on her cart to air dry at 12:08 PM. At 12:10 PM the glucometer was observed to be dry. At 12:18 PM Nurse #1 used the same glucometer to check Resident #54's blood sugar.

During an interview on 10/11/2017 at 12:20 PM, Nurse #1 stated the policy and procedure for using glucometers at the facility was to use the germicidal wipe to give one swipe on the front, one swipe on the back and three swipes across the top, bottom, and sides of the glucometer. She further stated she always used this technique before and after each resident.

minutes between residents according to the manufacturer□s recommendations for resident #54. Nurse#1 had not read the instructions on the cleaning/disinfecting container.

Resident #54□s next scheduled blood sugar was checked using a properly cleaned/disinfected glucometer.

It is the intent of the facility to clean and disinfect the glucometer using the manufacturer□s recommendations for resident #54 and the other 12 diabetic residents that require finger stick testing using a glucometer.

On 10/11/17 nurse #1 was in-serviced by Clinical Care Coordinator on: Cleaning and disinfecting glucometer between residents. The glucometer will be cleaned and disinfected for four (4) minutes and air dried.

On 10/11/17 nursing staff RN□s, LPN□s and MA□s were in-serviced by Staff Development Coordinator on Cleaning and disinfecting glucometer between residents. The glucometer will be cleaned and disinfected for four 4) minutes and air dried.

The Director of Nursing/Clinical Care Coordinator will monitor the use of glucometers weekly using an audit rounds tool to maintain that the glucometers are being cleaned properly and in accordance to the manufacturer's recommendations.

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F 441	Continued From page 7 During an interview on 10/11/17 at 2:02 PM, the Infection Control Nurse stated it was her expectation the nursing staff would follow the manufacturer's directions when cleaning the glucometers and stated the glucometer should have remained visibly wet for four minutes. During an interview on 10/11/17 at 2:13 PM, the Director of Nursing stated she did not know there was a time limit for cleaning glucometers, but they just needed to be cleaned with a bleach wipe and let it dry before and after each use. She then stated the glucometer should have remained wet for a minute. After reading the label on the wipes used by the facility she stated it was her expectation the nurse would leave the surface of the glucometer visibly wet for four minutes before letting it air dry per the directions on the germicidal wipes label.	F 441	On 10/17/17 new cleaning and disinfecting product was ordered. The new cleaning and disinfecting wipes will be implemented after nursing staff have been in-serviced. Any identified problems related to improper cleaning of the glucometers will be reported to the QI Committee by the Administrator/Director of Nursing. The QI Committee will review any identified concerns times 3 months, followed by quarterly X1, and as needed. Identified problems will be corrected immediately to maintain regulatory compliance.	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F 520		11/4/17

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F 520	Continued From page 8 (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's Quality Assessment Committee (QA) failed to maintain implemented procedures and monitor the interventions the committee put into place in January 2017. This was for a deficiency which was originally cited in January 2017 on a federal monitoring survey and was cited again on the current recertification and complaint investigation survey. The deficiency was in the area of infection control. The continued failure of the facility during two federal surveys of record demonstrate a pattern of the facility's inability to sustain an effective QA program. The findings included:	F 520	F520 The facility was directed to order new cleaning and disinfecting wipes in March 2017 but implemented them without reading and educating RN's LPN's and MA's to the new product. It is the intent of the facility to maintain implemented procedures and monitor interventions developed by the facility's Quality Assessment Committee (QA) to	

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F 520	Continued From page 9 This tag is cross referenced to: F441: Based on observation, staff interview and record review the facility failed to disinfect the glucometer between resident uses according to manufacturer's recommendations for 1 of 2 resident's observed for glucometer checks (Resident #54). Infection Control (F441) was originally cited on the federal monitoring survey on January 13, 2017 for failure to properly handle intravaneous tubing to prevent risk of cross contamination. During an interview with the Clinical Coordinator on 10/12/17 at 11:30 AM she stated the QA committeed had completed a QA project but it was not related to infection control. During an inteview with the the Administrator on 10/12/17 at 11:40 AM she reported the QA Commitee met monthly to discuss and monitor numerous topics. The members who attended included the DON along with more than 3 members of the management team. She stated the physician attended quarterly and provided a signature sheet to confirm attendence at the last quarterly meeting.	F 520	ensure an effective QA program. It is expected that any new product recommended by corporate will be implemented only after the Director of Nursing/Staff Development Coordinator have read and educated/in-serviced nursing staff on proper use before implementation. The QI committee recommended a QAPI on “Failing to clean glucometer according to manufacturer’s recommendation” be completed. QAPI was completed on 10/11/17. The facility plans to have an outside educator Cathy Fischer RN, Infection Control Prevention Coordinator from East Carolina Medical Center in-service nursing staff on “Infection Control Techniques and “Cleaning and Disinfecting a Glucometer” in the future. The Director of Nursing/Staff Development Coordinator will monitor the proper use of the new cleaning and disinfecting wipes weekly after nursing staff training and implementation completed. Any identified problems related to glucometer cleaning will be reported to the QI Committee by the Director of Nursing/Staff Development Coordinator. The QI Committee will monitor monthly times 3 months, followed by quarterly X 1, and as needed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 520	Continued From page 10	F 520	Identified problems will be corrected immediately to maintain regulatory compliance.	